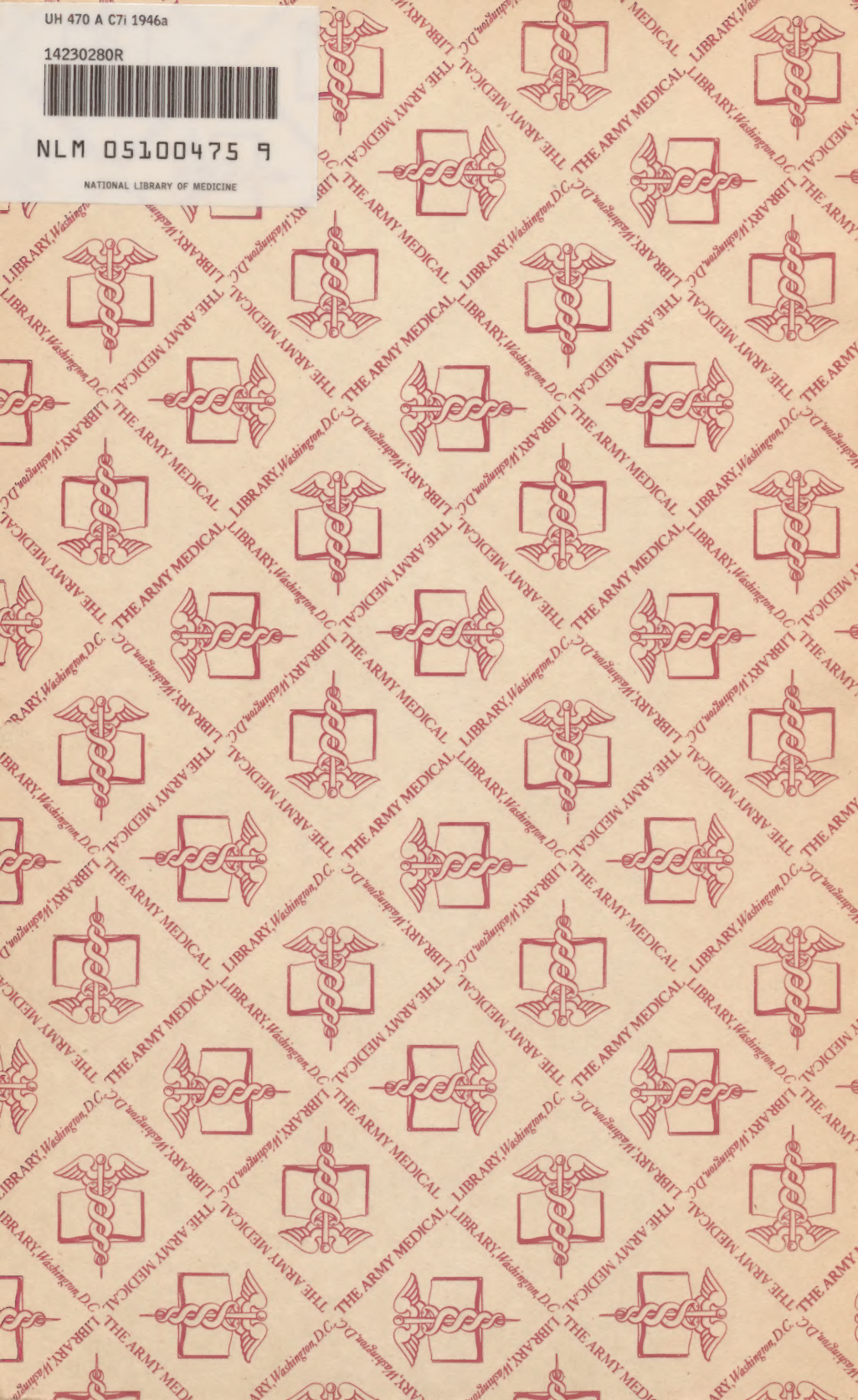

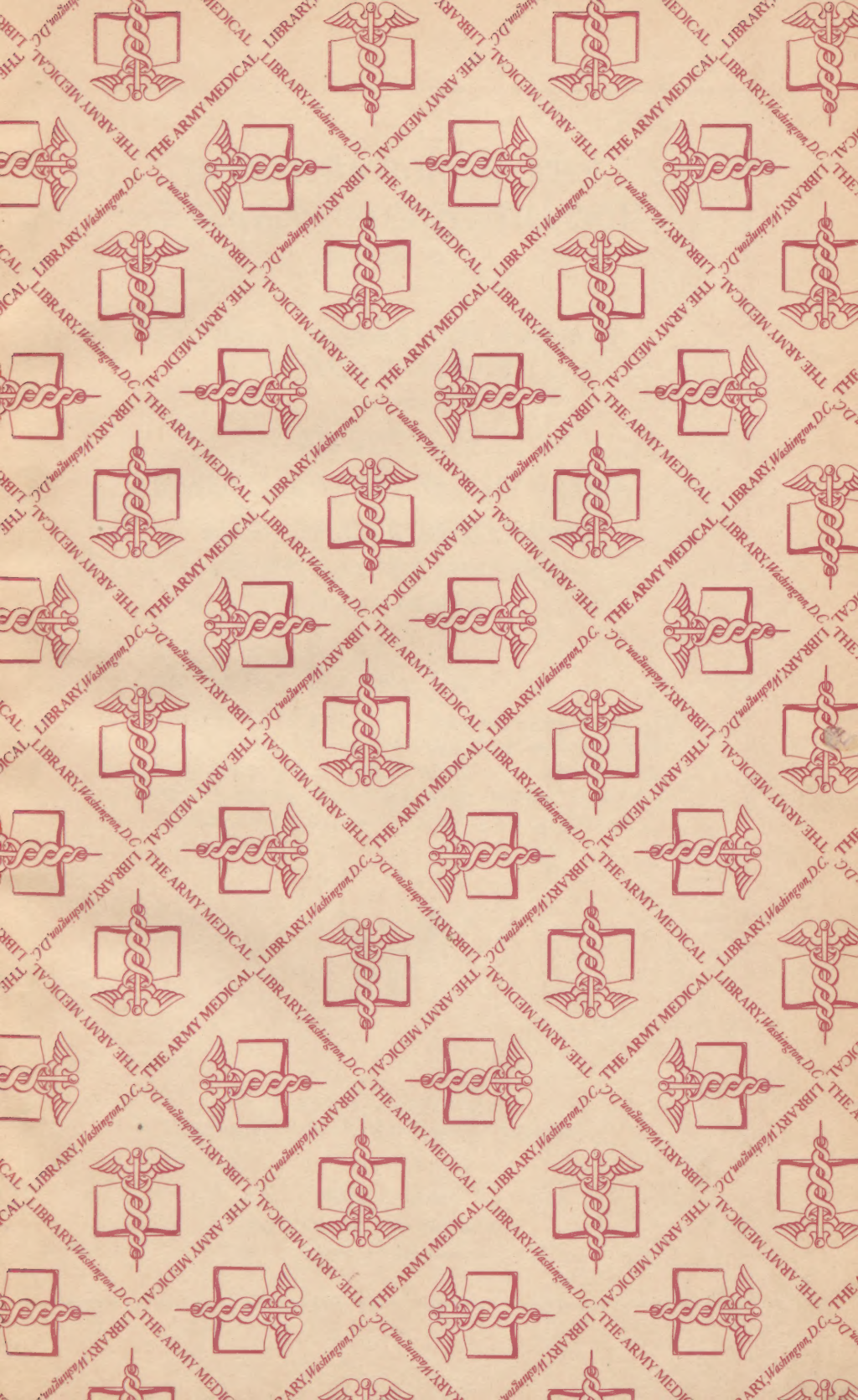
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INVESTIGATION OF THE VETERANS' ADMINISTRATION

COUNSEL'S REPORT AND SUMMARY OF THE EVIDENCE

FOR THE

COMMITTEE ON WORLD WAR VETERANS' LEGISLATION

HOUSE OF REPRESENTATIVES

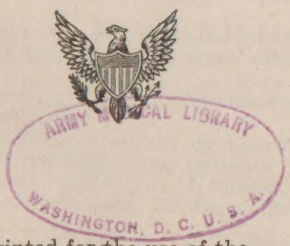
SEVENTY-NINTH CONGRESS

SECOND SESSION

ON

H. Res. 192

A RESOLUTION TO PROVIDE FOR AN INVESTIGATION OF THE VETERANS' ADMINISTRATION WITH A PARTICULAR VIEW TO DETERMINING THE EFFICIENCY OF THE ADMINISTRATION AND OPERATION OF VETERANS' ADMINISTRATION FACILITIES



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COMMITTEE ON WORLD WAR VETERANS' LEGISLATION

SEVENTY-NINTH CONGRESS

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CONTENTS

	Page
Foreword	v
Introduction	1
Testimony by—	
Adams, Dr. Roy D., secretary, special medical advisory group	49
Baird, Col. John H., Assistant Medical Director, Veterans' Administration	9
Bradley, Gen. Omar N., Administrator of Veterans' Affairs	86
Cohn, Mr. Milton D., Disabled American Veterans	22
Cutler, Dr. Max, member, medical advisory group	45
Deutsch, Albert (witness subpenaed)	8
Griffith, Dr. Chas. M., Medical Director, Veterans' Administration	54
Haley, Col. Frank, Military Order of the Purple Heart	24
Head, Dr. Jerome, consultant, thoracic surgery, Chicago, Ill.	72
Hightower, Dan, Fairbanks, Alaska	15
Hines, Brig. Gen. Frank T., Administrator of Veterans' Affairs	63
Ijams, Col. George E., Assistant Administrator, Veterans' Administration	61
Ketchum, Omar B., Veterans of Foreign Wars	21
Kidd, Raymond C., Director of Supply Service, Veterans' Administration	61
Kraabel, T. O., the American Legion	18
Lorenz, Dr. William F., member, medical advisory group	51
MacEachern, Dr. Malcolm T., member, medical advisory group	46
Maisel, Albert Q. (witness subpenaed)	8
Murphy, Dr. Charles P., Veterans' Administration	52
Myers, Doe, Rochester, N. Y.	9
Philbin, Hon. Philip J., Member of Congress, State of Massachusetts	2
Piersol, Dr. George Morris, chairman, medical advisory group	42
Stansfield, Harry, Investigation Division, Veterans' Administration	38
Tripp, Louis H., Director of Construction Service, Veterans' Administration	58
Verdel, Col. Louis F., Veterans' Administration	26
Wolford, Col. Roy A., Assistant Medical Director, Veterans' Administration	13
Exhibits—	
Analysis of exhibits A to ZZ, inclusive (chart)	4
Assaults by attendants upon patients submitted to Department of Justice	67
Assaults by patients reported to Department of Justice	69
Branch office areas (map)	Facing 84
Dates of correspondence received by Congressman Philbin (chart)	3
Deaths resulting from assaults by patients	68
Medical inspection, Northport Hospital, department of mental hygiene, State of New York, Dr. Bascomb B. Young, acting medical inspector	28
Monetary benefits to veterans and dependents on June 30, 1945	84
New organization (chart)	Facing 84
Old organization (chart)	Facing 82
Patients remaining in all hospitals (chart)	81
Status of full-time physicians, nurses, and attendants	57
Survey of United States Veterans' Administration hospitals by American College of Surgeons	47
Report on inspection of Veterans' Administration facility, White River Junction, Vt., Hon. Sherman Adams, Member of Congress (not a member of the Committee on World War Veterans' Legislation)	75

	Page
Reports by subcommittee—	
Allen, Hon. A. Leonard	75
Auchincloss, Hon. James C	75
Bennett, Hon. Marion T	75
Carnahan, Hon. A. S. J	75
Cunningham, Hon. Paul	74
Domengeaux, Hon. James	75
Gibson, Hon. John S	75
Kearney, Hon. Bernard W	74
Ramey, Hon. Homer A	74
Scrivner, Hon. Errett P	74
Vursell, Hon. Charles W	75
Service to the veteran—	
Administrator, the	86
Care and treatment	80
Compensation and pension	83
Construction	82
Decentralization	79
Employment	78
Hospitals	75
Mentally ill, the	76
New organization	85
Old organization	82
Special medical advisory group	42
Veterans' organizations	16
Veterans' organization reports	25

FOREWORD

This volume is a summary of the evidence introduced in the investigation of the Veterans' Administration, authorized by House Resolution No. 192, for the benefit of the Committee on World War Veterans' Legislation in the preparation of their report and is not to be considered in any way a report of the committee.

The testimony introduced in the current investigation has covered some 3,000 pages, which is bound in seven volumes. The summary of the evidence covers the period from May 15, 1945, to approximately October 1, 1945.

JOE W. MCQUEEN, *Counsel.*

INVESTIGATION OF THE VETERANS' ADMINISTRATION

INTRODUCTION

The Committee on World War Veterans' Legislation was authorized in January 1924, and since that time has been a standing committee (House of Representatives) of the Congress of the United States.

The investigation conducted by the Committee on World War Veterans' Legislation was authorized by House Resolution 192, Seventy-ninth Congress, first session, under date of March 27, 1945. (Record, pt. 1, p. 61.) The resolution authorized the committee acting as a whole or by subcommittee to conduct an investigation of the Veterans' Administration, with a particular view to determining the efficiency of the Administration and operation of Veterans' Administration facilities.

The Veterans' Administration is an independent governmental agency, responsible and accountable direct to the people of this country through the Congress of the United States and the President.

The Veterans' Administration was authorized and established as an independent agency under the direction of the President in July 1930, by Public Law 536, Seventy-first Congress, which further authorized the President by Executive order to consolidate and coordinate under a single control all Government agencies having to do with the administration of laws relating to the relief of and other benefits provided by law for former members of the military and naval forces. By Executive order there was established the Veterans' Administration and consolidated therein the Bureau of Pensions, the United States Veterans' Bureau, and the National Homes for Disabled Volunteer Soldiers.

The Administrator of Veterans' Affairs is charged with the control, direction, and management of all agencies and activities comprising the Veterans' Administration and all final decisions or orders of any agency of the Veterans' Administration are, on appeal, subject to review by him. The Administrator of Veterans' Affairs is chairman of the Federal Board of Hospitalization, which Board is advisory to the President in all matters having to do with the need for, the location of, and expenditures on account of increased Government hospital and domiciliary facilities. The Administrator of Veterans' Affairs is also chairman of the Veterans' Placement Service Board, which Board was created by the Seventy-eighth Congress to cooperate with and assist the United States Employment Service, so as to provide for veterans the maximum of job opportunity in the field of gainful employment.

The Veterans' Administration is responsible for extending relief to veterans and dependents of deceased veterans of all wars, and persons and dependents of deceased persons who served in the Military and Naval Establishments of the United States during other than a period of war, provided for by the various acts of Congress. These laws include, in addition to pensions, benefits in the form of Government insurance, hospital and domiciliary care, vocational

rehabilitation and education, the guaranty of loans for purchase or construction of homes, farms and business property, and readjustment allowance for veterans.

The Director of the Veterans' Bureau, Brig. Gen. Frank T. Hines, was in July 1930 named as Administrator of Veterans' Affairs. He has served well and his long tenure of office as Director of the Veterans' Bureau and Administrator of Veterans' Affairs, having served the veteran, the dependent of the veteran, and his Government for almost a quarter of a century, reached into the term of four Presidents of the United States. On August 15, 1945, he was succeeded in office by Gen. Omar N. Bradley. The Veterans' Administration is at this time the largest independent governmental agency in the United States. It has been estimated that the Veterans' Administration was on June 30, 1945, carrying approximately 20 percent of the work and supervision that it would be called upon to assume in taking care of the veteran and his dependents, dating back through World War II, World War I, Spanish-American War, Civil War, Indian wars, Mexican War, and one dependent (by special act) of a veteran of the War of 1812.

This committee, on September 17, 1945, under authority of House Resolution No. 192, and after due consideration of the testimony then at hand, submitted an interim report pertaining only to inadequate space and personnel.

THE TESTIMONY

Hon. Philip J. Philbin, M. C.

The committee called as the first witness on May 15, 1945, the Honorable Philip J. Philbin, Member of Congress from the State of Massachusetts. Mr. Philbin had, on Wednesday, March 7, 1945, introduced a resolution calling for a broad inquiry into all veterans' activities and not restricting his resolution to Veterans' Administration activities. In view of the speech delivered by Mr. Philbin on that date (Congressional Record, 79th Cong., 1st sess., p. A–1125) and Mr. Philbin's speech of Saturday, March 24, 1945, pertaining to veterans' hospitals (Congressional Record, 79th Cong., 1st sess., p. A1537) this committee desired to have the benefit of his information outlined in the two speeches.

It was revealed after Mr. Philbin's statement before the committee and questions by the committee for several days that the charges made were based upon correspondence received by Mr. Philbin from all parts of the United States, all of which bore dates of March 7, 1945, and subsequent thereto. In the speech delivered by Mr. Philbin on March 24, 1945, pertaining to veterans' hospitals, he has quoted from letters he had received, with the exception of exhibit D (record, pt. 1, p. 90) which was not addressed to him and came to the committee through another source. This letter bore a date 6 days after Mr. Philbin made his speech of March 24, 1945. The complete letters, from which these quotations were taken, were afterward introduced in the record and identified as exhibits A to ZZ inclusive (record, pt. 1, pp. 85 to 124).

Congressman Philbin delivered to this committee through its counsel 398 letters, telegrams, and post cards. The following chart will show the dates of such communications. There were 23 letters which did not bear a date and the envelopes not having been retained it was impossible to tell the dates the letters were written; however, all of the

23 letters referred to the matter of an investigation and in most cases to press notices of Mr. Philbin's speeches and resolution, which would indicate they were written subsequent to March 7, 1945. The chart will show the dates on the 375 letters delivered to the committee by Mr. Philbin (23 letters not dated).

March 1945		April 1945		May 1945	
Date	Number of letters	Date	Number of letters	Date	Number of letters
1		1	3	1	5
2		2	10	2	2
3		3	6	3	3
4		4	6	4	1
5		5	6	5	
6		6	6	6	3
7	3	7	3	7	2
8	24	8	1	8	1
9	14	9	6	9	1
10	6	10	7	10	
11	4	11	9	11	3
12	20	12	4	12	2
13	8	13	3	13	1
14	6	14	2	14	
15	10	15	4	15	(1)
16	8	16	5		
17	4	17	2		
18	1	18	1		
19	7	19	2		
20	4	20	2		
21	3	21	1		
22	3	22	7		
23	8	23	3		
24	8	24	3		
25	26	25	2		
26	22	26	1		
27	12	27			
28	17	28	3		
29	7	29	2		
30	9	30	1		
31	11				
Total	240	Total	111	Total	24

Total letters dated March, April, and May, 1945	375
Total letters not dated	23
Total letters delivered	398

[1] Mr. Philbin called as witness.

It is interesting to note the great number of letters bearing a date just after the press release by Mr. Philbin on March 7, 1945 (record, pt. 1, p. 143) and the magazine article which appeared on the newsstands at approximately the same time (record, pt. 1, p. 145), and then again after Mr. Philbin's speech on March 24, 1945 (Congressional Record, 79th Cong., 1st sess., p. A–1537). The speech of March 24, 1945, carried quotations from letters received by Mr. Philbin subsequent to March 7, 1945, and prior to March 24, 1945.

The total of 398 letters turned over to the committee by Congressman Philbin included 26 letters now in the record without the names of the writers (record, pt. 1, pp. 85 to 124). These letters speak for themselves. However, the following chart will show something of the status of the veteran as to his service connection, nonservice connection, when the veteran served, the amount of pension or compensation received, and the nature of his disability. Not all of the letters were written by veterans. Some were written by wives, mothers, and sisters, and one by a person covering State, county, municipal, Army, Navy, Veterans' Administration hospitals, and in fact all classes of hospitals throughout the United States.

Analysis of exhibits A to ZZ, inclusive (record, pt. I, pp. 84 to 124)

Identification	Date of letter	Service-connected	Non-service-connected	Military service	Pension or compensation per month	Nature of disability
A	Mar. 15, 1945		100 percent	World War I	$50.00	Bronchial asthma, hernia, and others.
B	Mar. 13, 1945	30 percent		World War II	34.50	Bronchiectasis, C. D. D. from Army.
C	Mar. 7, 1945		100 percent	Spanish-American	75.00	Psychosis, arthritis, incompetent.
D	Mar. 30, 1945					Written and signed by same person identified as C.
E	Mar. 13, 1945	Less than 10 percent	100 percent	World War I	50.00	Psychoneurosis.
F	Mar. 14, 1945			World War II		Navy hospital; unable to identify.
G	(1)			do		Army hospital; veteran's name not given; unable to identify.
H	Mar. 8, 1945	None	None	World War I	None	Nephritis, valvular heart disease.
I	Mar. 16, 1945			World War II		Army-Navy hospital; veteran's name not given; unable to identify.
J	Mar. 15, 1945	None	100 percent	World War I	None	Misconduct case, psychosis, incompetent.
K	do	do	do	do	50.00	Tuberculosis.
L	Mar. 18, 1945	do	None	do	None	Myocarditis.
M	Mar. 7, 1945	do	do	do	None	Drug addict, less than 90 days' service.
N	Mar. 9, 1945	10 percent		World War II	11.50	Psychosis unclassified.
O	Mar. 12, 1945			Nonveteran		Refers to general conditions in all hospitals.
P	Mar. 13, 1945	24 percent		World War I	None	Flat feet, varicose veins; compensation waived by veteran.
Q	do	30 percent		Spanish-American	75.00	Heart condition.
R	Mar. 10, 1945	29 percent		World War I	33.35	Psychoneurosis.
S	Mar. 12, 1945			do		Nervous disorder; Army hospital; veteran's name not given; unable to identify.
T	Mar. 14, 1945	None	None	World War II	None	Constitutional psychopathic.
U	Mar. 13, 1945			World War I		Veterans' hospital; veteran's name not given; unable to identify.
V	Mar. 10, 1945			World War II		Anonymous; Navy hospital.
W	Mar. 12, 1945	100 percent		do	112.50	Tuberculosis; retirement pay.
X	Mar. 15, 1945	None	100 percent	Spanish-American and World War I.	100.00	Service pension.
Y	Mar. 12, 1945	10 percent		Peacetime	8.62	Peacetime veteran.
Z	Mar. 8, 1945			World War II		Navy hospital; no record of veteran.
ZZ	Mar. 12, 1945			Spanish-American		Death case.

[1] Undated.

The above analysis of exhibits A to ZZ, inclusive, shows, in part, the following:

Two veterans are incompetent and under guardianship.

Seven, including the above two, are suffering from some mental disorder.

Ten exhibits from veterans suffering from non-service-connected disabilities.

Eight suffering from service-connected disabilities (one of whom had a service-connected disability of less than 10 percent and a non-service-connected disability of 100 percent).

Six could not be identified from the contents of the letter.

One referred to a death case.

One from a nonveteran and mentioned no relatives who were veterans.

One anonymous.

Twelve letters pertained to veterans who served in the military service in World War I.

Nine who served in the military service in World War II.

Four who served in the Spanish-American War (one of whom had served in both Spanish-American and World War I).

One peacetime veteran.

One nonveteran.

One veteran of World War I with a service-connected disability of 24 percent, who has rehabilitated himself, and is employed in one of the large cities in this country, has waived compensation.

One World War II veteran who has 100 percent service-connected disability and is receiving retirement pay.

One drug addict who had less than 90 days' service.

Of the remaining 372 letters, 149 were checked at random for intensive investigation. Limitations of time and available personnel necessarily precluded such treatment of each individual letter received by the various members of the committee or by Congressman Philbin, and it seems clear that a representative sample number carefully analyzed will as accurately reflect the situation as would such treatment of a larger number of letters. A careful study of the 149 letters intensively analyzed reflects the following:

Sixty-four of the letters were from writers afflicted mentally to the extent that little, if any, weight could be given their statements.

Forty-four of the letters to Congressman Philbin complained of the denial of a claim for compensation or pension, or the denial of an increase in the amount thereof. It will be understood that this is a technical and involved subject, depending in part upon the facts as to the physical condition of the veteran at the time of his medical examination, and more particularly upon the amount of disability resulting from those ailments which are properly held to be the result of his military service. This, of course, is generally an administrative matter under existing laws and regulations and is not an appropriate subject for investigation by a legislative committee. However, an individual report was obtained on each case. In a few instances the appropriate official of the Veterans' Administration indicated that a further examination or review of a recent examination would be made in order to be certain that the current rating was correct. In most cases it appeared evident that it was correct. Some of the

letters indicate a misunderstanding of the law, which is perhaps more or less general, namely, that as to veterans of the two World Wars compensation or pension is payable only for the disability which was caused by the military service, except in those instances where such veteran is totally and permanently disabled, in which event a non-service-connected pension may be paid. One case was found to present an unusual factual situation which did not meet the requirements of the rating regulation for non-service-connected pension; however, on July 5, 1945, the claim was allowed after being considered.

Twenty-one of the letters alleged mistreatment, either physically by an attendant, or failure to give medicine or afford specific treatment, or supply one or both as quickly as the writer thought it should have been supplied. The facts of each of these were inquired into and the complaints found to be without merit. In a few instances it appeared that perhaps the patient had a different conception of the medical treatment from that entertained by the attending physician. Necessarily the physician's opinion as to what medical treatment is appropriate must prevail.

Six of the letters were from employees, or former employees, complaining of some personal controversy outside the scope of the investigation.

Three of the letters in this group related to Army and Navy hospitals, which are not within the scope of the resolution.

Two of the letters complained about the type or quantity of food. Each hospital and other facility of the Veterans' Administration prepares the menus some days in advance. Any changes necessitated in the menus (because of market conditions or otherwise) are noted so that the final filed menu reflects what is actually served at each meal. These menus for each meal served at all of the Veterans' Administration hospitals are kept on file for a period of time and traveling supervisors make periodical checks to determine what is being served. The quality and quantity of food purchased is of record. The only meritorious complaints about food were, in a few instances, where, because of mechanical break-down in food transportation carts, the food was not as hot as it should have been when it reached the patients on the wards. A careful check into this situation demonstrated that it resulted from failure of certain electrical appliances made from composition rubber in the early days of the war, which deficiencies were later corrected. The committee is convinced that, with few exceptions, the food served in Veterans' Administration hospitals is of good quality, adequate quantity, and generally well-prepared and well-served. In the course of the investigation various members of the committee visited a number of the veterans' hospitals and partook of the same food that was served to the patients. In most instances these visits were without prior notice.

One letter complained about the hospitalization of the writer's cousin, a veteran under guardianship because of a mental disability, and who had been legally committed by the State court. The propriety of his commitment was determined by the court, not by the Veterans' Administration.

One letter was from a veteran whose claim had been forfeited, in accordance with the statutes, because of the submission of false

evidence in support of his claim. He was also convicted under the criminal provisions of the statute. His mental condition was considered separately by the Veterans' Administration and by the pardoning attorney of the Department of Justice, and both concluded that he was sane at the time he committed the offense.

One letter was from a young man in the active naval service who was worried about his father, a World War I patient. Contact with the father resulted in the report that he was contented at the Veterans' Administration hospital where he was a patient. His reaction was that his son was unduly worried about him and he promised to write his son immediately.

One letter complained that in the claims division in a certain Veterans' Administration facility many men who work on the claims have never served in the armed forces themselves. The writer believed that the positions should be filled by men who have seen fit to serve their country in time of war. The facts show that of 63 staff employees of the adjudicating division of the facility complained of, 4 were in uniform, having been assigned by the armed forces; 1 is the widow of a deceased ex-serviceman, and 37 are ex-servicemen. In adjudication of claims, decisions in such matters are based on applicable statutes and it is not felt that the performance of military duty is a prerequisite for the assignment of such work. To fill all positions having to do with adjudication work with people who have rendered military service would not seem to be administratively feasible or practicable. However, in these positions, as well as in other positions where factors are equal, first consideration is given to persons entitled to military preference.

One letter complained that while being hospitalized for a mental condition the writer lost a substantial amount of property. An analysis of this man's financial condition shows that he not only did not have any property when hospitalized but was very much in debt and that his wife had to maintain the household for many years previous to the time he had been hospitalized.

One letter from a recently discharged man from the United States Army complained that he had to pay for his own treatment. Available records indicate that he had not applied to the Veterans' Administration up until midsummer 1945 for any treatment.

One letter complained of the lack of treatment at a Veterans' Administration hospital. The record shows that all of this man's treatment was secured at Army hospitals prior to his discharge, and, upon application for hospitalization at the Veterans' Administration after careful diagnosis the record shows no hospital treatment was indicated.

One letter complained that he was badly disabled by service in World War I, yet stated in his letter that he only served 1 week in a training camp. A careful search of the records of the Veterans' Administration fails to disclose that a claim for benefits has been filed, or that he has received treatment at any Veterans' Administration facility. From the writer's own statement it would indicate that he was rejected for active military service.

One letter complains of treatment at a Veterans' Administration facility as not being adequate and that he is dissatisfied with the handling of his claim for pension. The veteran was hospitalized from July 21, 1944, to October 11, 1944. The veteran has been found to be

permanently and totally disabled for pension purposes and an award of pension has been made.

The remaining 223 letters were classified but not analyzed and would fall in the following groups:

One hundred and seventeen were general complaints and suggestions as to how to operate hospitals, administer veterans' funds, pay insurance, classify veterans' claims, etc.

Thirty-three were anonymous.

Twenty-nine desired to testify before the committee.

Twenty-four, the information in the letter was not complete and it was hard to understand just what the writer was trying to point out, and many of these letters could easily fall within another classification above set out.

Twenty letters did not concern the subject matter of the investigation:

Mr. Philbin's testimony, together with the examination by counsel and members of the committee, consumed the better part of 2 days. After the testimony of the witness was in the record and his personal knowledge of conditions was before the committee, the summary of his testimony could best be stated by referring to the record itself. We quote:

Mr. SCRIVNER. Then March 24 you made the statement that conditions in Government hospitals are unspeakable "and of that we have abundance of evidence."

Mr. PHILBIN. Yes.

Mr. SCRIVNER. Now, the evidence I presume are the letters you have been receiving?

Mr. PHILBIN. Yes.

Mr. SCRIVNER. So that none of the information upon which you have based your statements in the record and here are based upon personal knowledge?

Mr. PHILBIN. That is true. * * * (Record, pt. 1, p. 132.)

Mr. VURSELL. I would like to ask the witness if he knows about how many patients there are in the various hospitals under the Veterans' supervision, approximately?

Mr. PHILBIN. No. I do not believe that offhand I would know.

Mr. VURSELL. Well, you would not know how many of them are classified as psychoneurotic?

Mr. PHILBIN. No; I would not have any figures regarding the break-down of those various categories.

Mr. VURSELL. Now, for your information there are about 65,000 patients of this great organization, coming from the families over the Nation; and of that 65,000 about 45,000 of them are in various degrees mental cases.

Now, the question I would like to put to you is in view of the fact that you say now that you have no knowledge of your own of the ill treatment or maltreatment of these patients, rather than to alarm the whole Nation would it not have been better to have gone into conference with the Veterans' Committee here and possibly General Hines and tried to work this thing out without hurting the morale of the relatives by the millions over the United States, when it comes to the finish here now that you have a few letters, many of them unsigned, from people, most of them mental cases, whose testimony would not be taken as fully credible in any court?

I am rather amazed at the situation we are in here. (Record, pt. 1, p. 133.)

Witnesses subpenaed

The next two witnesses called by the committee were subpenaed. The first, a reporter for a metropolitan newspaper, and the other a free-lance writer, who had articles in a nationally known magazine pertaining to the Veterans' Administration hospitals. Each of these witnesses (lay witnesses), in their articles appearing in the newspapers, magazines, and their testimony, treated of highly technical

and medical problems neither of which impressed the committee nor brought any information to the committee of value in the current investigation. By the testimony of these witnesses it was shown their information was gained by short interviews with heads of different departments in the Veterans' Administration and others, and still shorter visits to a few of the hospitals operated by the Veterans' Administration. (Record, pt. 1, pp. 188, 191, 192, 193, and others; pt. 2, pp. 591, 610, 618, 637, 648, 814, 815, 820, 822, and others.)

The charges directed at the Veterans' Administration by these writers both in the articles published and the testimony, while serious, were more on the journalistic and sensational side and offered little to this committee of a real, constructive nature upon which the committee could act. The magazine articles will be found in the record, part 1, pages 145 and 319. Several of the articles by the reporter for the metropolitan newspaper will be found in the record, part 1, pages 175, 177, and 180. The testimony of each of the witnesses will be found in the record, part 1, pages 165, 186, 222, 263, 291 to 326; part 2, pages 586 to 662.

Some idea of how the testimony of these witnesses was received may be gained by referring to the record.

Mr. CUNNINGHAM. I don't question for one moment your sincerity, but I question your good judgment as to how you went about this, because I see 15,000,000 soldiers who will eventually be veterans, and all of their relatives, disturbed by your article all out of proportion to the facts you have already disclosed to this committee. And that is a dangerous thing.

Mr. ———. I think that situation could be easily resolved if this committee and the Veterans' Administration simply continue along the line that has been followed in the last 2 months, of cleaning up the situation.

Mr. CUNNINGHAM. The only way I think that it can be alleviated is for you to write an article—do it yourself; you are the one that started it—and let this committee correct the evils that you have done. (Record, pt. 1, pp 256–257.)

NOTE.—See Cosmopolitan magazine, November 1945, pages 24, 25, 217, 218, 219, 220, 221, 222. See Reader's Digest, December 1945, page 85.

Mr. Doe Myers

Many individuals appeared and requested permission to testify before the committee. After going over their statements and talking with these individuals who had proffered their testimony, it was found that a great many of them wished only to appear in behalf of themselves and, in most instances, on account of compensation or pension which they were or were not receiving. One witness, Mr. Doe Myers, of Rochester, N. Y., who had insisted upon appearing before the committee, and in his own words stated:

The writer would at this time request that he be given the opportunity to appear before the special committee appointed to investigate the veterans' hospitals. He has a story to relate that sounds like fiction, but this story can be corroborated by documentary facts. It reaches from the medical staff of the veterans' hospital at Batavia, N. Y., up to the Administrator of the Veterans' Administration, Mr. Frank B. Hines * * *. (Record, pt. 1, p. 523.)

The statement of Mr. Myers is in the record (record, pt. 1, p. 522), and speaks for itself. This committee thereafter decided that no other individual as such, in the interest of their own claim, would be called before the committee.

Col. John H. Baird

The committee called as a witness Col. John H. Baird, Assistant Medical Director in charge of the Neuropsychiatric Division of the

Medical Service. Dr. Baird holds a bachelor of letters degree from Kenyon College in Gambier, Ohio; a degree of doctor of medicine from Johns Hopkins University, Baltimore, Md.; and is a fellow of the American Psychiatric Association; a fellow of the American College of Physicians; member of the Association of Military Surgeons; and a diplomate of the American Board of Psychiatry and Neurology. Dr. Baird served in the Medical Corps of the United States Army in World War I, and entered the Government service in 1921; has served 24 years in the United States Public Health Service, Veterans' Bureau, and Veterans' Administration. Dr. Baird was on the witness stand for about 2½ days and under cross-examination by counsel and all members of the committee. His testimony was confined solely to the Neuropsychiatric Division of the hospital system operated by the Veterans' Administration throughout the United States, and particularly in New York and other Eastern States where articles had appeared by the two writers previously mentioned. Dr. Baird's knowledge of the subject and of the department which he heads seems in every way to be thorough, his testimony was very instructive and helpful in advising the committee on problems of hospitalization for the veterans of this and other wars. His testimony and prepared statement are very conservative and approaches a most troublesome subject in a very scientific manner; he presented his evidence to the committee in a way that it could be understood by any layman interested in the subject.

The complete testimony of Dr. Baird will be found in the record, part 2, pages 673, 703, 731, 747, and 783 to 813.

Dr. Baird in his testimony was asked for a definition of "neuropsychiatric" and to divide it into the divisions which are used in the Veterans' Administration medical set-up and answered as follows:

* * * the term "neuropsychiatric" is an all-inclusive term that is applied to any case showing nervous or mental symptoms.

Now, roughly, we might divide that large group into two parts. First, the psychoneurotic group, and, second, the psychotic group. The psychoneurotic is an individual who apparently has an insoluble mental conflict that he expresses unconsciously through various symptoms.

Of course, we are surrounded by those symptoms every day.

Like being upset because one has to testify, for example, which might cause one of the symptoms that simulate a psychoneurosis. A mother overanxious about a child, or a father about financial matters, or a girl jilted in love—she has certain symptoms that make her actually sick. Well, of course, when the stimulus that causes these symptoms is removed, then the symptoms are usually gone, in a normal person.

The psychoneurotic is one in whom these symptoms persist more or less indefinitely, after the original stimulus has been removed. We have many of those, of course, to deal with.

* * * from the press, one would think every man who is discharged from the service as a psychoneurotic is a very bad case and requires immediate care by the Veterans' Administration. That is far from the truth; it is not a fact. A relatively small percentage I should say of that psychoneurotic group need therapy for any appreciable length of time.

Our plan is not to hospitalize the psychoneurotic unless he is disabled. Some of the overseas cases will need hospitalization.

A small number will need out-patient care, either with our clinic or some private clinic * * *.

Now, the psychotic group require hospitalization until they reach the point where they can handle themselves in society * * *.

One who is suffering from psychosis is one who has distorted reality, and to the point of making himself unable to get along in society.

A psychoneurotic gets along after a fashion, but the psychotic has what one psychiatrist—I think it was Bleuler in Europe—termed it "schizophrenia,"

from the Greek schizo, meaning to split; the splitting of the mind in which the individual is emotionally ill. He does not have the normal appreciation of emotional feelings.

For example, in lots of the cases of psychosis, dementia praecox, the patient will not receive the news of a death in the family with any more emotion than he would that he cannot have a cigarette today or there are no points for dinner.

In other words, there is a leveling of the emotional functions, general attitude, lack of interest, lack of self-respect, and, later on, if the patient is not treated, and sometimes if he is, mental and intellectual deterioriation.

There are various grades and gradations of those psychoses, and there are various causes.

But one might say that a psychosis is an all-pervading thing that involves the entire personality to the point of putting this person out of circulation, whereas the psychoneurosis does not * * *.

* * * unfortunately, the term "psychoneurosis" has been used by certain people to mean insanity, and it does not at all. Only a relatively small proportion of those patients, discharged veterans, or men discharged from the Army are psychotic or insane. Most of them are not * * *. (Record, pt. 2, pp. 676–677.)

I know this, that so many of those who are discharged from the Army with a diagnosis of psychosis and admitted to one of our hospitals do not need treatment.

In other words, they have presumably had what might be called a situational psychosis, brought on by Army training and what not. When they reach our hospitals they have practically recovered. Now, whether they will break down again later on in life is something we cannot say.

* * * * * * *

What we expect—I am not speaking authoritatively—in our hospitals from now on out for treatment of mental patients there will be the normal number of men and women that would break down in civil life.

In other words, considering the fact that we have in round numbers 15,000,000 people in this Army and in the armed forces this time, we will expect just a certain percentage of those to require hospitalization * * *. (Record, pt. 2, p. 678.)

* * * In the first place, as I said before, I think we will get for treatment in our hospitals patients who have psychoses in proportion to the population * * *.

* * * I think it might be a little higher than in the general population because of the age of the veterans. Most of them are in their early twenties, thirties, and we know that dementia praecox, which is the mental condition that comprises the vast majority of admissions to State institutions, is more prevalent in young people * * *. So we might expect the incidence to be higher than in civil life.

And then of course there will be many of these severe psychoneurotics that have come from the battle zones that do not get better that will filter into the hospitals. (Record, pt. 2, p. 681.)

In speaking of mental cases that are sufficiently cured to leave the hospital, Dr. Baird stated:

* * * fiscal year of 1944 here is a chart showing the results of treatment of those veterans discharged from the neuropsychiatric facilities, the one we are talking about now. A total of 20,129 were discharged * * *.

Now, of that number hospitalization was completed in 14,589. In other words, in 72.5 percent hospitalization was completed. The others were discharged before hospitalization was completed.

Now, the majority of those being World War II cases discharged against medical advice. They are sent to our hospitals by the Army, and in many instances their family is waiting on the doorstep to take them home, not giving us a chance to examine them at all, give them any treatment.

The Veterans' Administration has no recourse, nothing else to do but let them go. (Record, pt. 2, p. 682.)

In speaking of the use of restraints for mental cases, Dr. Baird had this to say:

* * * under medical-control seclusion, camisoles, restraining sheets, wristlets, are quite necessary, and are adjuncts to treatment, and are in the best interest of the patient * * *.

That looked rather horrible in the magazine. But a man who is homicidal and very disturbed sometimes has inflicted considerable damage to personnel and to other patients.

You could keep him under drugs continuously, you could lock him in a room and keep him there indefinitely, but we feel that is not a humane way to treat those men.

So in cases of that kind, a very few, we feel that it is better to have them have the freedom of the ward so that they may exercise, and get on the porches, and even get out on the lawns. They can eat their meals with these contraptions on, they can smoke cigarettes, they can read books and play checkers, and yet they cannot take a swing at another patient or a doctor or an attendant or a nurse. It is utterly impossible while he has that on * * *. (Record, pt. 2, p. 683.)

* * * we feel that kind of thing is a kindness to the patient, rather than a torture. Those patients for whom that kind of thing is used are those who are so belligerent and hyperactive mentally and physically, chiefly physically, that they are a menace to those about them as well as a menace to themselves.

They may be suicidal, or homicidal, or both.

Now we could, as I said before, keep those men under sedative constantly, some kind of drug. We could keep them in packs, neutral packs, which we do sometimes to try to calm them down, but in most instances of those who are homicidal, packs do not do any good. Nor do tubs do any good.

Those wristlets are taken off at regular intervals for a rest, especially when they take them to the lavatories, and taken off at night, and taken off completely when they have demonstrated that they can get along without them. (Record, pt. 2, pp. 699–700.)

Being questioned about the use of shock treatment, Dr. Baird stated as follows:

* * * In every one of the hospitals we use the electric-shock treatments, the electric shock, the insulin shock, and fever therapy.

The treatment program is a very elaborate affair.

In the first place, a neuropsychiatric hospital is a control institution where the doctors and nurses and technicians and the aids in different departments like occupational therapy and physical therapy, the laboratories and educational aids and physical directors, all work together in the interest of the patient, and we divide the treatment into parts, you might say, group therapy.

They are treated in groups, and in that therapy which embraces the correction of any physical defect, the electric-shock therapy, the giving of insulin therapy, psychotherapy, the giving of interviews by the physician on the ward, he takes the patient into his office and discusses his difficulties with him.

I do not think that you will find any therapy that has been accepted by the profession that is not employed in our (Veterans' Administration) hospitals. (Record, pt. 2, p. 687.)

Dr. Baird in discussing recreational programs at NP hospitals, and speaking of patients who do not have controlled recreational supervision, had the following to say:

Of course that is a situation we have been trying to combat for years, and succeeded in pretty well up until this war, when so many of our personnel were taken away, our trained personnel, aides, attendants, and psychiatrically trained nurses.

What we had for that was an organized program of group games and classes of different kinds and visits to the library, to break up the monotony of the day, and with that sort of thing this sitting around was reduced to a minimum.

But I suspect now that with conditions as they are in our hospitals because of lack of trained personnel there have been instances of drifting back into the practice of not being able to get them occupied. (Record, pt. 2, p. 787.)

In speaking of the expansion program for additional beds for neuropsychiatric patients, Dr. Baird had the following to say:

The Veterans' Administration does not only claim it is building hospitals and additions to presently operated hospitals as fast as it can, but it claims this to be a fact. It also admits that the building program has not kept up with expectations or plans. The reasons for the delays in the completion of building projects include the question of priorities for materials, delays in deliveries of materials, strikes,

manpower shortages, and certain unforeseeable structural difficulties. The program calls for over 20,000 additional beds to be made available before the end of the calendar year 1946, of which nearly 8,000 will be ready for occupancy by July of this year; over 4,000 by January 1946; 5,000 by July 1946; and the remainder toward the end of the year 1946. It is expected that this number of additional beds will meet the needs of the Veterans' Administration for psychotic patients for the period concerned. (Record, pt. 2, p. 797.)

Col. Roy A. Wolford

The committee called as a witness Col. Roy A. Wolford, Assistant Medical Director, Tuberculosis Division, Veterans' Administration. Dr. Wolford holds a degree of doctor of medicine from the University of Maryland; he is a fellow of the American College of Chest Physicians, a governor of the college, a member of the membership committee, and a member of the council on military affairs, a member of the American Trudeau Society, and a member of the Association of Military Surgeons. Dr. Wolford was a member of the Medical Corps of the United States Army in World War I. He entered the United States Public Health Service as a Reserve officer in 1920 and has been in service in the United States Public Health Service, the Veterans' Bureau, and the Veterans' Administration since that date. Dr. Wolford is a specialist in internal medicine. His testimony pertains only to the treatment of tuberculosis in the hospitals operated by the Veterans' Administration; is straightforward and to the point, and he has in his statement given many facts as quoted from hospital records, which facts have a great bearing on articles published by certain magazines and periodicals throughout the United States. (Record, pt. 2, pp. 825, 826, 827, 831, 832, 833.) Dr. Wolford's testimony before the committee was enlightening, instructive, and interesting. While strictly technical, it was presented in such a manner that it was readily understandable by a committee of laymen. The testimony and a statement of Dr. Wolford will be found in the record, part 2, pages 814–873.

The testimony of Dr. Wolford is mostly in defense of charges which have been made against the Veterans' Administration, and particularly on the care of veterans suffering from tuberculosis, the department which he heads, and in part Dr. Wolford stated:

* * * Also during the reconstruction program the rooms constructed for day rooms were necessarily used temporarily for housing the patients. This was essential, due to the urgent demand for beds. However, at no time were any of the rooms overcrowded. The alterations and reallocation of space were made in accordance with standard plans allotting at least 70 square feet of space for each bed. * * * The toilet facilities of all the wards were increased where rebuilding was involved. There was provided a special day room on each ward which did not exist prior to the construction, and there is an adequate nourishment kitchen on each ward. During the alteration period at no time did the bed capacity of a five-bed room exceed six beds, or did a two-bed room exceed three beds as a temporary expedient.

If the committee wishes, we have the plan here of hospital building No. 15 at Castle Point before the remodeling and after the remodeling, which you may be interested in seeing. (Inserted in record, pt. 2, between pp. 816 and 817.) You will note that we provided more private rooms for the patients than were there before the remodeling, and that the day-room space was increased, and several other features, which is part of a modern tuberculosis hospital, remembering that the Castle Point facility was constructed originally about 1923, when the ideas about tuberculosis hospitals were very much different than they are today. (Record, pt. 2, p. 816).

In speaking of the care and cure of patients in tuberculosis hospitals, Dr. Wolford had the following to say:

The term "cured" is rather loosely used by certain un-informed laymen, and I regret to say even by some hospitals and physicians. In Veterans' Administration hospitals a patient is discharged as cured only when the condition for which he had been treated has actually reached that state. Acute diseases will frequently result in a cure after hospitalization, but most chronic diseases will actually only be improved. This is especially true of tuberculosis and nervous and mental disabilities. In our tuberculosis hospitals, if we are to follow the National Tuberculosis Association classification, no patient can be discharged as even apparently cured for this requires the resumption of the normal activity of the patient for a 2-year period under the usual routine of life without any constitutional symptoms of the pulmonary disease developing. * * * (Record, pt. 2, p. 835.)

* * * Among the (1944) tuberculous patients discharged 2.9 percent were arrested, 1.1 percent apparently arrested, 1 percent quiescent, 30.9 percent showed improvement, and 28.5 percent were unimproved; 19.7 percent died while the condition was not stated in 15.9 percent.

Among the younger veterans of World War II suffering with pulmonary tuberculosis discharged during the fiscal year 1944, of 4,075 patients discharged during that year 164, or 4 percent, were discharged as arrested; 88, or 2.2 percent, were discharged apparently arrested; 60, or 1.5 percent, were discharged as quiescent; and 1,360, or 33.4 percent, were discharged as improved. (Record, pt. 2, p. 838.)

If you remember, we told you our death rate was 19.7 percent. * * *

I may go back to the comparative analysis of miscellaneous data on non-Federal tuberculosis hospitals and tuberculosis facilities of the Veterans' Administration and pick out the total discharge and mortality rates percent from a number of hospitals, to show you how it varies from hospital to hospital.

The mortality rate for the Pima County Hospital in Arizona was 40 percent. The Essex County Hospital in Massachusetts was 23.7 percent. The Matapan City Hospital was 37 percent. The Middlesex County Hospital in Massachusetts was 31.2 percent. The Glen Lake Sanitorium in Minnesota was 21.9 percent.

In 11 hospitals in New York City the mortality rate was 19.3 percent. In the Metropolitan Hospital in New York City the mortality rate was 39 percent; the Tri-Borough, New York City Hospital, was 21.8 percent; the Seaview Hospital in New York was 20.9 percent; the Jefferson County Beaumont Hospital, * * * the total mortality rate was 26 percent for white, 57 percent for colored. (Record, pt. 2, p. 839–840.)

We feel the patient should be treated as near home as possible. He is then more contented. He can have his family visit him, and he will stay in the hospital and take treatment, and we don't recommend any change of environment for patients. * * *

The old type of tuberculosis sanatorium was built with those so-called open porches and the cubical type. All modern thought now is that they should be built exactly as a general hospital. The treatment is, in a certain percentage of cases, surgical. As to the so-called fresh air and sunshine, we found that too much sunshine is bad for people with pulmonary tuberculosis. And for fresh air—if you will remember, 15 or 20 years ago they used to show pictures of patients going out in the snow with just a loincloth on, maybe. Well, that is very detrimental to tuberculous patients, in the opinion of the Veterans' Administration. (Record, pt. 2, p. 841.)

Generally the patient should have bed rest. Then he must have good food, of course. He must be contented. He must have as few financial or personal worries as possible. Then you must give consideration to so-called active treatment; in other words, rest for that lung. If the bed rest doesn't do it, we can then utilize the so-called pneumothorax, or we can go into surgical procedures. In pneumothorax we just splint that lung by injecting air into the pleural cavity, which compresses it so much that every time the man breathes in and out it does not expand and contract.

* * * that is the so-called pneumothorax, which is probably the most frequently employed in tuberculosis. However, there are certain contraindications or certain auxiliaries which have to also be given. In other words, if a patient has adhesions of the lung which are holding it against the chest wall so it will not collapse, then they have to go in there and cut the adhesions, and that is what we call pneumonolysis. In other words, we go in there with a thoracoscope, look at the adhesions, then clip them with the cautery or what not, and drop it back, then induce a pneumothorax. If that is not effective, they use a so-called thoracoplasty, which is cutting away a large number of ribs, anywhere

from three to seven, depending altogether on the involvement, and they catch most of the ribs clear back to the spine and almost to the front of the sternum, and that collapses the lung.

Then, in certain types of cases * * * where they had involvement of only one lung, they go in there and take that lung out. * * * (Record, pt. 2, p. 842.)

In speaking of the aptitude of doctors and nurses, together with the treatment of tuberculous patients, Dr. Wolford had the following to say:

* * * They (tuberculous patients) have been sick a long time, but they are not as sick, considering their pulmonary involvement, as you would expect if you saw a man with a broken leg or a fellow with appendicitis. In other words, he is too sick to worry too much about surroundings sometimes, but a tuberculous patient is very critical. In other words, I don't know of a harder patient to treat or a type of patient that takes a better doctor to treat than tuberculosis. * * * (Record, pt. 2, p. 843.)

* * * He may have other complications. He may have, for instance, diabetes or he may have an ulcer of the stomach, or something else, but if he has active pulmonary tuberculosis we want to treat him in a tuberculosis hospital, and we want, of course, to have him in an environment where he can be contented and he can be given the best medical care. (Record, pt. 2, p. 844.)

In speaking of the care of the patient and requiring him to remain in the hospital as pertaining to Veterans' Administration hospitals, Dr. Wolford said:

* * * in other words, compulsion is not the way to treat tuberculosis, you see. What we have got to do in treating tuberculosis is to sell the treatment to the patient. You can tell him that he has got to be in bed 24 hours of the day, but if he is not contented lying there, or doesn't believe he needs it, you haven't helped his condition very much. So I don't think the mere fact of keeping the man in the Army is the answer to the problem. Our problem is greater education. We have got to sell in some way the cure to the patient, and compulsion is not the way to do it. (Record, pt. 2, p. 845.)

In speaking of the rating for tuberculosis hospitals operated by the Veterans' Administration, Dr. Wolford had the following to say:

The only rating for a hospital is to be recognized by the American College of Surgeons. They survey all the hospitals in the United States at stated intervals, and they accept them, either accept them or reject them, and that is the only standard for hospitals. * * *

Every veterans' hospital except one is rated as accepted by the American College of Surgeons, and that happened to be a hospital which we just opened in April, and the American College of Surgeons has not had an opportunity to survey it yet. (Record, pt. 2, p. 846.)

Mr. Dan Hightower

Mr. Dan Hightower, of Alaska, asked to file a statement before the Veterans' Committee in this investigation, which was permitted, and in part stated as follows:

In appearing before your committee I do so as the spokesman of World War II veterans and veterans-to-be. These service men and women are not only those who were recruited from or enlisted in Alaska, but those as well from the States who are going to Alaska to live after the war is over. This latter group, based upon the best estimates which can be made at this time, will greatly outnumber those who lived in Alaska at the time of entering the service.

We have no indictments to present to the committee against the Veterans' Administration beyond complaints of failure to act in doing what Congress has already provided in legislation for the women and men doing our fighting for us. * * * (Record, pt. 2, pp. 891–892.)

"Functions of the Veterans' Administration under recently enacted laws for World War II veterans mean more than erecting, equipping, and operating hospitals. For example, there are the services of disability claims and their presentation, and vocational training for the disabled, both closely allied with hospitalization;

and the services of accredited representatives other than Veterans' Administration employees, submission of discharges for review, rights of dependents, estates of decedents, education, loans, unemployment compensation, liaison with other Government departments and agencies and with the Selective Service System on employment rights and priorities not necessarily related to hospitalization. * * * They cannot be handled properly by remote control. We insist here, however, that hospitals are the present and future indispensable item in properly administering veterans' facilities in Alaska the way the Congress has provided for.

"Congress has wisely taken into consideration the limited separate financial abilities of United States possessions such as Alaska in providing in this new servicemen's law that the Administrator of Veterans' Affairs is authorized and directed to establish new facilities in centers of population where there is no Veterans' Administration facility, or where such a facility is not readily available or accessible. Congress in this law has also taken cognizance of the fact that Alaska belongs to all the people in all the States * * *." (Record, part 2, p. 893.)

The ones for whom I speak do not and will not advocate expenditures of money on an ornament or edifice. Instead, what we want in Alaska is a service institution. If a suitable building is not available in the place to be selected for the principal veterans' hospital, one will have to be built. Decentralization of functions to officials of such a facility should include authorization to send patients having unusual ailments to institutions in the States especially equipped to treat such diseases. Alaska asks just what Congress intends for us to have, viz: Veterans' Administration facilities in charge of persons empowered to act. (Record, pt. 2, p. 894.)

The following members of this committee, Hon. John S. Gibson, Hon. Paul Cunningham, and Hon. Marion T. Bennett, acting as a subcommittee, and in conjunction with other duties and other committees during the summer vacation made an extensive investigation in the Territory of Alaska. Mr. Hightower, in representing the veterans of Alaska, feels that there should be a Veterans' Administration facility of some kind for the benefit of veterans in the Territory of Alaska. Some members of the committee feel that in the interest of the veterans of Alaska, and because of the transportation and communication difficulties between the Territory and the States, that a regional office of the Veterans' Administration should be established in Alaska as well as a veterans' hospital. Under the new organization approved by the Administrator on September 14, 1945, this regional office would report direct to the Deputy Administrator in district No. 11, at Seattle, Wash.

Veterans' Organizations

The committee had the benefit of the testimony and statement of Col. John Thomas Taylor, director, national legislative committee, the American Legion, and Mr. T. O. Kraabel, director, national rehabilitation committee, the American Legion; Mr. Omar B. Ketchum, national legislative representative, Veterans of Foreign Wars of the United States; Mr. Casey M. Jones, assistant director, national service bureau, Veterans of Foreign Wars of the United States; Mr. Milton D. Cohn, national commander, Disabled American Veterans, and Col. Frank Haley, national service director, Military Order of the Purple Heart. Dr. Albert N. Baggs, medical consultant, national rehabilitation committee, the American Legion, assisted Mr. Kraabel in presenting to the committee the reports prepared by the several representatives of the American Legion on hospitals throughout the United States. Mr. William E. Tate, national director of claims, Disabled American Veterans, assisted Mr. Milton D. Cohn, national commander, Disabled American Veterans.

All of the above witnesses are veterans. All appeared before the committee as representatives of recognized veterans' organizations and all know the problems of the veteran, both from the position of the Veterans' Administration and the individual veteran in the hospital. These witnesses introduced reports from committees within their organizations throughout the United States and brought to the committee a wealth of information from the veteran through the local committees, and from the standpoint of the veteran. All of the evidence introduced by these witnesses was lay testimony (with a few exceptions in the field where medical men submitted reports). The reports in many instances as to hospitals are duplications of the American Legion, Veterans of Foreign Wars of the United States, and the Disabled American Veterans and were submitted by the members of the several organizations and, in most instances, made by men from the State and city in which the hospital or facility is located, and in all cases were made without remuneration to the men who compiled the reports. It is believed that the recognized veterans' organizations over the past quarter of a century have been the beacon light and best guidepost for legislation for the benefit of those who had served their country in time of war and particularly those who were disabled. The gathering of the information and dissemination of knowledge on this subject has not been a matter of a few days or few weeks, but all recognized veterans' organizations have been vigilant in their efforts and outspoken in their zeal to secure the proper information and very quick to transmit such information to the Veterans' Administration and to this committee for the good of the ex-service man in general and the disabled man in particular.

Two volumes of the hearings of this investigation, part 3 and part 4, with the exception of 1 day, are devoted exclusively to information furnished this committee by the veterans' organizations; and now, referring particularly to a small part of that testimony, we wish to set out in part the information and show the forethought of these great organizations in their desire to improve the administration and operation of all veterans' hospitals and administrative offices. Referring to the declaration of policy in 1921 of the then newly created committee (the American Legion) on rehabilitation of veterans:

> Your committee would feel that it failed in its duty if it neglected to remind the members of the Legion generally that the problems connected with the care of our disabled comrades have not yet been solved. Thirty thousand of them are today in hospitals, a greater number than at any time since the armistice. Acute diseases and minor injuries have been successfully dealt with, but of those in hospitals today a large majority are suffering from serious disorders which may result in their death or in lifetime invalidism. While others may tire of the burden imposed by the care of these men and popular interest grow cold, the American Legion must never permit its interest to diminish or its energies in their behalf to lag until to the last one has been brought all the resources that modern science can provide for the cure or amelioration of the diseases from which they suffer. However, the Legion might succeed in other activities, it will fail if we do not continue to discharge our obligations to these comrades. (Record, pt. 3, 906–907.)

And again, at the Los Angeles, Calif., convention of the American Legion in September 1938, a resolution setting out the declaration of policy of that organization, the American Legion, said:

> Whereas it is the belief of this committee that the Veterans' Administration should remain an independent agency; and

Whereas the combining of Veterans' Administration activities with those of other Government agencies doubtless will result in less effective service to the disabled; and

Whereas the great inconvenience, and even hardship, may result through chaos and uncertainty incident to the combining of Veterans' Administration activities with other Government functions; and

Whereas it is the desire of our organization to protect the disabled and to avoid any possibility of their suffering unnecessary hardships: Be it therefore

Resolved, That the American Legion, in twentieth annual national convention assembled in Los Angeles, September 19, 20, 21, and 22, strenuously oppose any plan that would take away from the Veterans' Administration the independence it now enjoys or any move that would place any of its hospitals or facilities under the jurisdiction of any other Government agency or department. (Record, pt. 3, p. 907.)

And again, at the Milwaukee, Wis., convention in 1940, and up to the present time, and referring to the medical and hospital service in particular, the American Legion had this to say:

Resolved by the executive committee of the national rehabilitation committee, That a complete reorganization be made by the Veterans' Administration of its Medical Service; and be it further

Resolved, That in the process of reorganization of the Medical Service of the Veterans' Administration that the following terms of importance be considered:

1. A change in the direction and supervision.
2. Coordination and stabilization of all related services.
3. A more liberal delegation of authority to managers of field stations in the administration of the medical program.
4. The improvement of supervisory services of central office to eliminate duplications and the establishment of a new system, group or otherwise.
5. A revision of the present table of medical organization to provide for the replacement of those presently in the armed forces and to increase personnel in facilities where inadequacies now exist or may develop in the future based on the individual needs of each station, without regard to present ratio system.
6. The establishment of an improved system of promotion and transfer of medical and allied personnel based on merit and the dismissal from the service of admitted inefficient personnel instead of the present policy of transfer and further provisions for an adequate retirement basis for aged and disabled personnel.
7. Adequate training of specialists in various fields where the need for such specialists appears necessary. (Record, p. 3, pp. 907–908.)

Mr. T. O. Kraabel. The American Legion.

Mr. T. O. Kraabel, director, national rehabilitation committee, the American Legion, in his testimony before the committee on this subject, stated as follows:

I think it is significant that these expressions, made before the present war, have been largely substantiated by the findings of the current survey. We invite the attention of the committee members to the record of the Legion's presentation of these suggestions, the extensive studies and analyses which were stimulated by them, and the findings of the Administrator's referee committee and the subcommittee of the Medical Advisory Council. These findings point quite definitely to the need for change in the operation and control of this highly important branch of Veterans' Administration activity. Although some good was accomplished, the fundamental arrangement still remains.

By way of summation of what has been advocated during the past 5 years, we invite the attention of the committee to the following statement:

1. The Veterans' Administration and its services are created for the purpose, first and foremost, of administering laws and regulations in behalf of veterans, and not for special groups, units, or individuals.
2. The medical and hospital service of the Veterans' Administration is of such importance and proportions that it should be headed up by an outstanding man of medicine whose rank and status should be equal to that of Assistant Administrator.
3. There should be an inspired medical and hospital service, with more personal and bedside practice of medicine.
4. The positions and classifications should be upgraded.

5. Encouragement, authorization, time, and facilities should be afforded to the doctors of medicine, surgery, and dentistry for clinical or laboratory research, for attendance at appropriate professional meetings, and for contributions to the literature for advancement of medical science.

6. Chief medical officers and clinical directors should be given greater authority to run their hospitals.

7. The supervisory services of the central office should be coordinated so as to eliminate duplications and reduce to a minimum interference with the orderly functioning of these hospitals.

8. Special and meritorious services of individual doctors should be recognized through an improved system of promotion, and ineffective and disinterested personnel should not be retained.

9. Due recognition should be accorded the auxiliary activities, to the medical and hospital service, with the consequent upgrading thereof.

10. There should be a Medical Advisory Council of independent physicians and surgeons, meeting at regular intervals upon its own motion and not necessarily subject to call by the Veterans' Administration, this council to be open to presentations and recommendations by recognized veterans' organizations through their medical consultants, medical advisory boards, and designated officials.

11. There must be a revitalized program whereby the advancement and progress in medicine and surgery made by the armed services during this war shall be inherited and maintained by the Veterans' Administration, to the end that war veterans shall have the best science has to offer for their care and treatment. (Record, pt. 3, pp. 908–909.)

The American Legion, in a meeting of the executive committee of the National Rehabilitation Committee on June 1–2, 1945, in Chicago, Ill., adopted the following resolution:

Whereas the American Legion has from the very beginning advocated and fought for an independent Veterans' Administration, as expressed in resolution 98, Los Angeles convention, 1938; and

Whereas there are plans for the consolidation and reorganization of Government bureaus and other offices which may affect the status of the Veterans' Administration; and

Whereas the original Veterans' Bureau and its successor, the Veterans' Administration, were instituted to handle the affairs of less than 5,000,000 men; and

Whereas the country will eventually have a potential veteran group of some 18,000,000 men and women; and

Whereas the stupendous program and load which that agency is now carrying and will continue to carry for many years to come require strengthening and expansion of its activities, with continuance of a status free from amalgamation, consolidation, or inclusion in any other Government department or branch: Therefore be it

Resolved by the national rehabilitation executive committee of the American Legion, in meeting assembled at Chicago, Ill., on June 1–2, 1945, That the American Legion advocate and actively support:

1. The continuance of the Veterans' Administration as an independent governmental agency, responsible and accountable directly to the people of this country through the United States Congress and the President;

2. That the services and divisions of the Veterans' Administration be promptly enlarged and reorganized, to the end that the ever-increasing load which it faces be handled with promptness and efficiency; and be it further

Resolved, That the American Legion continue its all-out efforts to obtain further authority and decentralized procedure for all regional offices and facilities; and that regional offices are separated from combined facilities and established in downtown and work-load areas, to the end that service to the veterans and their dependents may be expedited and made more efficient. (Record, pt. 3, p. 909.)

The same committee, and at the same time, offered the following suggestions for the recommended expansion and realinement of the operating divisions of the Veterans' Administration:

1. Administrator of Veterans' Affairs.
2. A deputy Administrator of Veterans' Affairs.
3. An outstanding man of medicine to be an assistant administrator, or official of equal status, to head up the medical, surgical, clinical, dental, hospital, and domiciliary services.

4. An assistant administrator to head up all insurance activities, with establishment of an insurance unit in each of the regional offices throughout the country.
5. An assistant administrator at the head of the services of finance, loan guaranties, and readjustment allowances.
6. An assistant administrator for vocational training, rehabilitation, and education activities.
7. An assistant administrator to head up the adjudication of compensation, pension, and retirement claims.
8. An assistant administrator at the head of the services of construction, supplies, and contracts.
9. The decentralization of the Board of Veterans' Appeals to area boards of appeals.
10. The continuance of the legal, guardianship, personnel, budget, contact, and other administrative activities in conformity with this new alinement and expansion. (Record, pt. 3, pp. 909–910.)

It is very significant to note that either by chance or on account of adopting the well-thought-out and prearranged alinement suggested for the Veterans' Administration, the Veterans' Administration, with few exceptions, adopted, on September 14, 1945, the plan suggested by the American Legion under date of June 1–2, 1945.

Mr. Kraabel, in presenting the report and findings of the American Legion on the Veterans' Administration hospitals, had this, in part, to say:

The response of department commanders and their coworkers to the call of National Commander Edward N. Scheiberling for a study and report of each Veterans' Administration hospital has been most satisfactory. It should be pointed out that the department commanders and those who assisted them in the visitations are "folks" the same as are other veterans, whether of World War I or World War II. They know their States, the people therein, and the officials and employees at these hospitals. At the same time, they are ever vigilant to the cause and interest of the hospitalized man or woman and the folks back home. They have been frank in their appraisal, noting the faults, deficiencies, inadequacies in equipment, personnel, and procedure. With equal frankness they have expressed themselves as to the favorable findings and impressions. Everything considered, the consensus of all these reports may be expressed in the words: While the veterans of this war and their families should have no cause to worry or be concerned over the treatment received in Veterans' Administration facilities, there have been instances of neglect and there are changes which should be made to bring the standard of medical and hospital service to the highest point. (Record, pt. 3, p. 910.)

The summary of the investigation conducted at the request of the Veterans' Administration of all hospitals was then submitted for the record. These findings and recommendations are as follows:

1. Insufficient number of doctors, nurses, and other employees.
2. Additional beds required immediately to relieve crowded conditions in some hospitals and to prepare for the future load.
3. More authority to chief medical officers and clinical directors to operate their hospitals and to obtain required help.
4. Encourage doctors to participate in medical clinics, meetings, and symposiums and authorize the attendance of appropriate numbers to State and National medical gatherings at Government expense.
5. Stimulate real research and postgraduate work in those branches of medicine pertaining to the prevailing diseases and disablements suffered by war veterans.
6. Upgrading and reclassification of hospital and all Veterans' Administration employees, especially those in the lower brackets.
7. Increase and improve recreational facilities for World War II patients.
8. Increase space for canteens and improve the efficiency of operation thereof.
9. The contact service should be enlarged.
10. Relieve doctors of details connected with paper work, records, and other administrative matters, to the end that they have greater opportunity to practice bedside medicine.
11. Appropriate segregation of veterans, both as to groups and as to all kind of ailments. (Record, pt. 3, p. 910.)

Mr. Omar B. Ketchum, Veterans of Foreign Wars

Mr. Omar B. Ketchum, national legislative representative, Veterans of Foreign Wars of the United States, in presenting the summary of the investigation made by his organization, went into detail as to the requested investigation and placed in the record the outline of the set up by the Veterans of Foreign Wars of the United States for accomplishing the very helpful part which that organization played in bringing to this committee the findings on the Veteran's Administration hospitals throughout the United States. In presenting the matter to this committee Mr. Ketchum has placed in the record the list of questions to be answered as to each hospital in which an investigation was made. These 27 questions were agreed upon by the 3 major veterans' organizations, namely, the American Legion, Veterans of Foreign Wars of the United States, and the Disabled American Veterans. The questions furnished to each committee making the investigation and inspection of the hospital set a pattern for that service to be rendered for this committee. The questions referred to will be found in the record, part 3, pages 916–917. Mr. Ketchum, in submitting for the record the surveys and the reports of the Veterans of Foreign Wars of the United States, made 11 recommendations to the Veterans' Administration and to this committee, which were as follows:

1. Establishment of an independent board of review to hear complaints concerning the operation of hospitals and the treatment accorded veterans and report direct to the Administrator of Veterans' Affairs. This board would not be responsible under the law to any operating division of the Veterans' Administration This, it is believed, would permit hospital personnel and patients to offer constructive criticism without fear of reprisals

2. Higher pay for all hospital personnel, especially physicians, nurses and attendants, to attract, in some measure, the selection of those with the highest degree of skill and intelligence.

3. Authority to contract for hospital beds in State, municipal, or private hospitals for the care of veterans of all wars where Veterans' Administration beds are not available. Such contracts would be discontinued when adequate beds are provided by taking over Army and Navy installations, or the construction of new hospitals by the Veterans' Administration.

4. Establishment of out-patient centers in metropolitan areas removed from inaccessible veterans' hospitals now carrying the burden of this service.

5. More attention to be paid postgraduate courses for all physicians at stated intervals to assure the highest degree of medical skill, such courses to be at Government expense.

6. Outright firing of personnel found below standard, rather than the reported practice of transferring them to other veteran facilities.

7. Establishment of internship training at Veterans' Administration hospitals.

8. Restoration of full payment of compensation or pension to veterans undergoing hospital treatment irrespective of dependents. This, it is believed, will reduce materially the number of veterans leaving Veterans' Administration hospitals against medical advice.

9. That NP patients suffering from functional nervous disabilities, such as psychoneurosis, war neurosis, hysteria, be treated in separate hospitals from those receiving treatment for psychosis.

10. That psychotic World War I and World War II patients be separated from each other in NP hospitals. It is obvious that the young physically vigorous World War II veterans are more difficult to restrain when hyperactive than are World War I veterans in the same condition. Many of these young men have been taught to kill the enemy with their bare hands.

11. Devote more attention to educating the veterans of the necessity of remaining in the hospital until he has completed his examination or treatment. Also devote more attention to the proper instructions and training of hospital attendants. (Record, pt. 3, pp. 920–924.)

Mr. Milton D. Cohn, Disabled American Veterans

The Disabled American Veterans, through its national commander, Mr. Milton D. Cohn, in submitting a very lengthy and comprehensive report to this committee, stated that the surveys of the several Veterans' Administration hospitals throughout the United States were conducted by the rank-and-file members of the Disabled American Veterans, who are not professional investigators; that his report, therefore, represents the true picture of the conclusions of the average member of the Disabled American Veterans, based upon an objective and factual study of the problems at hand. Mr. Cohn, in presenting his report upon the survey and investigation of the Veterans' Administration hospitals throughout the United States, made the following findings and recommendations:

1. *Type of treatment.*—No drastic complaints were made concerning the type of treatment received in the various Veterans' Administration facilities. To the contrary, there was ample evidence that, for the most part, the medical care extended to disabled veterans in Veterans' Administration facilities is generally comparable in quality to that received in the best hospitals available to the ordinary citizen.

2. *Ratio of patients to full-time physicians, nurses, and attendants.*—As far as the investigators were able to determine, the number of physicians as compared to the number of patients they treated generally compared very favorably with those in other hospitals in the same area. It is to be emphasized, however, that this comparison does not reflect the ever-increasing number of patients entering the veterans' facilities and the possibility that the staffs are becoming greatly overloaded.

3. *Salaries of employees.*—To attract the required number of competent doctors, nurses, technicians, and attendants, their rates of pay should be made comparable to the rates of pay provided for similar services within the armed forces. A higher type of hospital attendants is definitely needed and can be obtained only if the pay scale is changed to conform with the prevailing rates of pay of unskilled labor in various communities. Subnormal wages for attendants will attract mostly the "floaters."

4. *Training and research.*—The research facilities of the Veterans' Administration should be vastly expanded. Provisions should be made for the doctors, nurses, and technicians to be given appropriate postgraduate courses, to keep abreast with scientific developments in the diagnosis and treatment of various diseases, defects, and ailments.

5. *Reduce "pencil pushing" for doctors and nurses.*—The great burden upon doctors and nurses of paper work, resulting from the making of medical histories, should be remedied by using trained medical historians to make such reports, for prior perusal by the examining doctors at the time of the examinations.

6. *Use of Wac's and cadet nurses.*—While it was felt by most of the investigators that the use of Army and Navy personnel should be abandoned as soon as possible, there were a number of specific requests that the cadet nursing program be continued. The use of this training program, according to a number of the regional managers, has been of great assistance and benefit in the handling of the patients.

7. *Crowding of patients.*—Many of the reports indicated that the hospitals are handling patients greatly in excess of the number for which they were originally intended. The only possible remedy for this situation where it exists is, of course, the building of enlarged quarters and of additional hospitals, as indicated more specifically in the reports of the individual facilities.

8. *Discharges against medical advice.*—The investigators found that in many instances no attempt was made to determine the precise reasons why patients left the hospital against medical advice. It is suggested that each patient be asked to reveal the reasons why he insists on leaving, when the recommendation of the hospital authorities is contrary. Where such records were obtainable, the most frequent reason for leaving against medical advice was merely a desire to be at home.

Most of the men of World War II should be given a 30-day furlough at home prior to their transfer to a Veterans' Administration facility. This would materially reduce the number of men leaving against medical advice. Where accurate figures were obtainable, the number of those leaving against medical advice did not exceed 5 to 7 percent of the total number of discharges.

9. *Length of hospitalization.*—The length of the period of hospital treatment—a matter quite properly under the jurisdiction of the medical officer in charge, involving a number of factors rather difficult to assay—was generally considered adequate.

10. *Training of patients.*—Appropriate correspondence courses should be extended to all patients desiring them, particularly as to the younger veterans of World War II, in addition to a more extensive and practical occupational therapy program.

11. *Recreational facilities.*—Recreational facilities—necessary and desirable in building up and maintaining the morale of patients—are, in many of the institutions, entirely inadequate.

Ample indoor and outdoor recreational facilities should be provided by an immediate building program, supplemented by the use of temporary structures where necessary.

A coordinated Nation-wide recreational program should be instituted by a trained staff of recreational directors, under the supervision of a central office recreational director.

12. *Canteens.*—The present canteen contract system should be discontinued and, in place thereof, the Veterans' Administration should set up a canteen system patterned after the Army post exchange set-up. Canteens in hospitals which are located in outlying areas should make food and refreshments available for visitors.

The canteen service in the several facilities varies greatly. In some instances it is practically nonexistent while in others it is fairly good—in some places they are located too far from the hospital wards and in other places they are crowded into small rooms.

13. *Supplies.*—There were a considerable number of objections to the character of restrictions and regulations under which the various facilities function. Objections were raised to the methods of purchasing supplies (exclusive of food), particularly as to the operation of the quarterly budget system.

A more efficient procedure would be to place the individual hospitals upon an annual budget, subject to the approval of the facility manager or the medical officer in charge, rather than to require repeated returns of individual requisitions to central office. The proposed purchase of an individual item of laboratory equipment, for example, involving approximately $100 or less, should not be delayed by its referral to central office for its concurrence.

14. *Transportation.*—Transportation to and from the Veterans' Administration hospitals is in two-thirds of the cases considered difficult, particularly as to short hauls from main-line terminals to the facility. More adequate provisions for shuttle transportation should, in such instances, be provided.

15. *Location of new hospitals.*—Additional new hospitals, with the exception of those for the treatment of tuberculosis, should be located close to communities and to direct transportation.

16. *Neuropsychiatric patients.*—Patients with neuropsychiatric ailments should be treated in general medical hospitals rather than in hospitals where mental incompetents are domiciled or treated.

Much of the social stigma attached to this term could be removed and the well-being of the patient advanced by treating him together with men suffering from more general disorders rather than to cause him to be housed with definitely psychotic individuals.

It also would be well to provide extensive out-patient treatment for these neuropsychiatric patients and to create a corps of psychiatric social workers to enter into the homes and to assist in the treatment of these individuals.

It might also be well to train employers in general as to the exact meaning of the neuropsychiatric ailments as compared with the mental or psychotic cases. (Record, pt. 3, pp. 932–935.)

The Disabled American Veterans, through their national commander, in appearing before the committee also emphasized certain other legislation for the benefit of disabled veterans. The national commander brought to the attention of this committee certain pending legislation which, in the opinion of his organization, would be most helpful for the disabled veteran, as follows:

1. Living cost allowances for the dependents of our service-connected disabled veterans, in the same amount as Canada provides for its disabled veterans and for their dependents, has long deserved favorable action by this committee and

by Congress. This could be accomplished by the enactment of H. R. 1872, introduced by the honorable chairman of this committee.

2. Increase the vocational training allowance of the handicapped veterans, up to the amount payable to handicapped veterans taking vocational training under the provisions of Public Law 16, that they would receive if rated totally disabled, as would also be provided for by the enactment of H. R. 1872.

3. Provide full compensation for single veterans while hospitalized as would be provided by the enactment of H. R. 556, introduced by Hon. J. H. Peterson of this committee. Single veterans while hospitalized may, under existing law, not be paid more than $20 per month by the Veterans' Administration so that a veteran who is entitled to $165 per month would, in effect, have to pay $145 per month for his treatment in a Veterans' Administration hospital.

4. Restore full compensation to so-called presumptives, as outlined in H. R. 575, also introduced by Mr. Rankin.

5. Provide the same compensation rates for disabled veterans of World War II as previously provided for veterans of World War I, for similar disabilities as provided by Mr. Rankin in H. R. 1936.

6. Provide a minimum 10-percent rating for all wounded and gassed veterans, as per H. R. 135.

7. Liberalize the National Service Life Insurance Act, so as to provide about the same benefits, options, and privileges as provided in the insurance policies issued to World War I veterans—the War Risk Insurance Act. This would be accomplished by the enactment of H. R. 2379, introduced by Mr. Rankin, with the joint sponsorship of the major veteran organizations. (Record, pt. 3, pp. 936–937.)

Col. Frank Haley, Military Order of the Purple Heart

Col. Frank Haley, national service director, Military Order of the Purple Heart, also appeared before the committee. Other than the three above recognized veterans' organizations, the Purple Heart is now recognized by the Committee on World War Veterans' Legislation. The Military Order of the Purple Heart restricts their membership to those who are the holders of the "Purple Heart" issued by the United States Government to men who have received wounds in combat with the enemy. The organization by virtue of its restricted membership is naturally small, numerically, yet it represents a class of men who are recipients of hospital care throughout the years by the Veterans' Administration hospitals. In the main, these are men who would be confined to general medical and surgical hospitals; however, many are at this time in both neuropsychiatric and tuberculosis hospitals.

Colonel Haley called to the committee's attention his inability to give a report on all hospitals as has been given by the other veterans' organizations and in his testimony covered for the committee the hospitals which had been visited and inspected by the officers and members of the Military Order of the Purple Heart.

Colonel Haley stated, in part, as follows:

> The Military Order of the Purple Heart being a comparatively—speaking numerically—small organization, not having representatives in all offices and facilities as have some of the larger veterans' organizations, enabling them to demand and receive reports from all over the country, we are unable to submit testimony covering all, but merely a few, of the largest hospitals such as Fort Snelling, Minn.; Wood, Wis.; Hines, Ill., general hospitals, and Coatsville, Pa., NP hospital. All of these were visited during the latter part of May by our national commander. * * *
>
> Aside from these, I personally visited Hospital 81, Bronx, N. Y., general hospital; Northport, Long Island, N. Y., NP hospital; and Lyons, N. J., NP hospital, on which conditions I will appreciate being permitted to testify.
>
> Information has been submitted to our Washington office by the representative of the MOPH in the Newington, Conn., facility, who in summing up points to various minor inequities existing, but states these are in fact due to inability of securing, when needed, all of the necessary equipment and supplies, the lack of personnel, and the overcrowded condition.

Our representative at Fort Howard, Md., submits that the hospital there is a comparatively speaking new hospital, is a fine hospital, immaculately clean, well managed, and that the patients are well pleased with conditions there. * * * (Record, pt. 3, p. 967.)

Colonel Haley, in testifying before the committee, made the following recommendations for the benefit of the committee, after the restricted inspections had been made by his organization:

No. 1. That immediate steps be taken to transfer from Hospital 81, Bronx, N. Y., the out-patient department, including the major portion of the dental clinic, only leaving a small dental clinic there for the benefit and use of in-patients. This would not only greatly improve existing conditions in the hospital itself as it applies to in-patients, but would be of great benefit to out-patients referred to earlier in my testimony. (Record, pt. 3, p. 971.)

No. 2. That steps be taken to materially improve the transportation facilities, not only of patients but of visitors to such hospitals at Northport, N. Y., and Lyons, N. J., which has also been referred to in my earlier testimony—that is included in my report covering these hospitals—and perhaps also to many other hospitals located in various sections of the country in what may be called isolated places away from existing main transportation arteries. (Record, pt. 3, p. 972.)

No. 3. The establishment of the medical department of the Veterans' Administration on a basis similar to that of the United States Public Health Service consisting of Medical Corps with the Surgeon General at the head of it being at least as free from lay and civil-service supervision as is at present the Surgeon General of the Public Health Service. (Record, pt. 3, p. 972.)

No. 4. In the establishment of such Medical Corps in the Veterans' Administration a rigid screening of the present medical personnel before admission to this corps should be carefully conducted and a high standard of admittance for future personnel maintained.

No. 5. Immediate steps be taken by the Administrator of Veterans' Affairs in conjunction with the head of the Personnel Bureau to rerate all employees for grading purposes with accompanying increase in salary, this to apply in particular to employees, men and women, having had long service in the Veterans' Administration, not only in central office but in the field, all regional offices, hospitals, and facilities.

No. 6. We advocate and recommend amendments to existing laws permitting the present glaring discrimination against single men without dependents being hospitalized. This committee is fully cognizant of such proposed amendments as they have on many occasions been before your committee in connection with new legislation introduced and considered and/or amendments to existing legislation. (Record, pt. 3, p. 973.)

Veterans' organization reports

A comparative chart on recommendations of the service organizations, namely, the American Legion, Disabled American Veterans, and Veterans of Foreign Wars of the United States, will be found in the record, part 4, pages 1840, 1841, 1842, and 1843. It is interesting to note that the three major veterans' organizations, while each operates distinctly separate, with different national headquarters in three different cities in the United States, and all with different headquarters in Washington, D. C., with no liaison between the three organizations with the exception, of course, of the members who belong to two or more of the different organizations, made recommendations that parallel each other in almost every instance. It is believed that the investigation made by the service organizations and their interest in the welfare of the veterans as a whole, and particularly the disabled veteran, is most helpful to this committee in the enactment of legislation and the proper administration of that legislation pertaining to the welfare of the veteran.

Reports on Veterans' Administration hospitals throughout the United States were submitted by the American Legion, Disabled American Veterans, and Veterans of Foreign Wars of the United

States. These reports of the different organizations will be found in the record, part 3 and part 4. They were introduced by States, alphabetically, commencing with the State of Alabama and closing with the Veterans' Administration hospitals in Wyoming.

The questions answered by the three veterans' organizations, which were the basis of the reports submitted to this committee, will be found in the record, part 3, page 916. The American Legion, in submitting their report, made a summarization and composite analysis of the answers to part of the questions. The summarization and composite analysis of the answer to:

Question No. 4, namely, "Do the manager, chief medical officer, and/or clinical director feel they have sufficient authority to run the hospital as efficiently as they might desire?" will be found in the record, part 4, page 1823.

Question No. 7, namely, "Do they have the encouragement and support in research, in participating in clinical meetings, symposiums, medical lecture courses, etc.?" will be found in the record, part 4, page 1825.

Question No. 8, namely, "What definite complaints, if any, are there as to the quality, quantity, variety, and preparation of food in the veterans' hospitals?" will be found in the record, part 4, page 1828.

Question No. 9, namely, "Have there been or are there any specific cases of alleged abuse or neglect of patients?" will be found in the record, part 4, page 1830.

Question No. 16, namely, "Is it felt that the discipline and morale of the patients are satisfactory?" will be found in the record, part 4, page 1831.

Question No. 18, namely, "Is the contact service considered satisfactory and adequate by the American Legion?" will be found in the record, part 4, page 1832.

Question No. 21, namely, "How do you find the discipline and morale of the hospital personnel? What are their complaints, if any?" will be found in the record, part 4, page 1833.

Question No. 22, namely, "What is your recommendation as to type and number of additional beds that may be required for the new load?" will be found in the record, part 4, page 1834.

Question No. 25, namely, "What percentage of patients without dependents leave the hospitals against medical advice due to the reduction in pension while being hospitalized?" will be found in the record, part 4, page 1835 (erroneously listed as question No. 24).

Question No. 26, namely, "Are there any complaints on the part of the patients regarding the lack of information given them as to their physical condition and advice as to future treatment upon being discharged from the hospital?" will be found in the record, part 4, page 1835.

The American Legion, in their report, also submitted high lights of the findings of investigators, which will be found in the record, part 4, page 1837.

Col. Louis F. Verdel

Dr. (Col.) Louis F. Verdel, manager of the veterans' hospital at Northport, Long Island, N. Y., was called before the committee. Many reports had reached the committee through the press, by

veterans' reports and personal letters, of maltreatment of patients and mismanagement of the hospital. The Northport hospital is one of the largest neuropsychiatric hospitals operated by the Veterans' Administration. Dr. Verdel has been in the employ of the Veterans' Administration since January 1, 1922, and has had several important assignments, including Roanoke, Va., for a number of years, and was transferred to Northport on June 16, 1944, and made manager of that hospital. Dr. Verdel's testimony was straightforward, he readily admitted abuse of patients which had been brought to light by undercover investigators, who had been placed in the hospital by the central office of the Veterans' Administration. Dr. Verdel did not in any way try to minimize the condition which he found upon taking over the management of the hospital, but in his own words stated:

> Well, I went there June 16. The hospital was terribly run down. * * * The physical condition of the hospital was run down; what we term the "clinical records" were behind; we had Army records there that were sent in for review that should be referred to the regional office within 10 days, that had been there, sometimes, as much as 2 months' time. (Record, pt. 3, p. 1252.)

Upon being questioned by the committee for his opinion of the fitness, by training or otherwise, of the doctors now stationed at Northport, to be in the veterans' hospital, Dr. Verdel stated that he was in an embarrassing position trying to serve two masters, the War Department and this committee, and then stated that he would rather not answer the question. (Record, pt. 3, p. 1264.) Dr. Verdel did, however, put into the record the names of five doctors, all of whom were placed on duty by the Army, who apparently were not cooperative or fitted in any way for service in a Veterans' Administration hospital. (Record, pt. 3, pp. 1262, 1263, 1264.) Dr. Verdel's testimony would strongly indicate that at least in some cases he was not properly supported in his recommendations by the central office, or at least the medical department of central office, Washington, D. C. Upon assuming the duties as manager of the hospital at Northport, in the opinion of Dr. Verdel he needed retention screens on windows in the acute building for the protection of the patients and others about the hospital, and after the matter had been at the central office for some month or two the request was turned down on account of the cost of the installation of such retention screens. (Record, pt. 3, pp. 1327–1328.)

Dr. Verdel's testimony brought to the committee the information that special undercover agents were placed in the hospital by the Veterans' Administration and that these undercover agents were not FBI investigators as had been published in many of the metropolitan newspapers. The complete testimony of Dr. Verdel before the committee will be found in the record, part 3, pages 1251 to 1337, inclusive.

At the time Dr. Verdel testified before the committee he had been on duty at the Northport, Long Island, N. Y., hospital approximately 1 year, and during that time there had been three careful inspections made by the Department of Mental Hygiene, State of New York, namely, August 7 and 8, 1944; November 20, 21, 22, 1944, and February 15, 16, and 17, 1945. These inspections were made by an outside agency and by medical men trained for such inspections. These reports are part of the records of the Department of Mental Hygiene, for the State of New York. It is believed that such reports

coming from outside sources, and by people having no connection with the Veterans' Administration, are very important and throw a great deal of light on the situation as it actually existed from the time Dr. Verdel assumed management of the Northport facility up to a few months before the time he testified. One of the inspections cover in detail much of the complaint which has been brought to the attention of this committee and for that reason is included in this report.

The items of special interest, together with the notes of the medical inspection, are as follows:

ITEMS OF SPECIAL INTEREST, MEDICAL INSPECTION, VETERANS' ADMINISTRATION FACILITY, NORTHPORT, LONG ISLAND, N. Y.—B. B. YOUNG, M. D., ACTING MEDICAL INSPECTOR—FEBRUARY 15, 16, AND 17, 1945

The manager of the facility has recently received a letter from the central office of the Veterans' Administration, Washington, D. C., relative to commitment of voluntary patients who were not considered suitable for continued care by the State medical inspectors. (See body of report for details.)

There were several accidents to patients where soldier attendants were involved. As noted in the body of the report, the manager can only recommend that guilty soldiers be court-martialed.

The facility has a large number of highly disturbed World War II veterans.

One social worker has been added since the last inspection, making a total of two social workers at present. These workers do no social work out of the hospital, however. The facility has no convalescent-status clinics.

A large number of patients are given occupational therapy and physical training.

The facility is very much overcrowded. This is reflected by the fact that many of the porches have had to be closed in to make room for beds, and beds have had to be put in other places where they really are not supposed to be. Five-foot centers between patients' beds are still being maintained.

Inspector was impressed by the small number of patients in restraint. Very good use is made of the pack rooms in this facility.

NOTES OF MEDICAL INSPECTION OF VETERANS' ADMINISTRATION FACILITY, NORTHPORT, LONG ISLAND, N. Y., FEBRUARY 15, 16, AND 17, 1945—DR. BASCOMB B. YOUNG, ACTING MEDICAL INSPECTOR

Last inspection, November 20, 21, and 22, 1944.

Inspector arrived 1:15 p. m., February 15, 1945.

Staff on duty: Louis F. Verdel, colonel, Medical Corps (manager), Lt. Col. H. E. Foster, Dr. Edward H. Lazell, Dr. A. Triolo, Dr. Leonard M. Brown, Dr. Lester Drubin, Dr. Richard P. Giliberty, Lt. Col. James H. Huddleson, Maj. William J. Turner, Lt. A. Carra, Dr. Maurice E. Herman, Maj. Angelo S. Naples, Capt. Robert J. Drake, Capt. Daniel Dancik, Capt. Leo H. Kashe, Lt. Col. Virgil B. Williams, Capt. Hirsch L. Gordon, Capt. James H. Hawkes, Maj. James Watson, Lt. Edgar Steinberg, Lt. Frederick Singer.

Staff off duty: None.

Staff vacancies: Three medical officers, one associate medical officer.

Patients

	Males		Males
Census, carried on rolls	3, 130	Patients at Veterans' Administration facility, Bronx, N. Y.	6
In institution (this includes 1 medical case, 3 allied cases, 3 domiciliary cases, and 1 E. C. C. case)	2, 823	Patients on convalescent status	241
Patients at Veterans' Administration facility, Bath, N. Y.	30	Patients on elopement status	19
Patients on leave of absence	11	Patients employed	None
		Capacity, authorized	2, 312
		Capacity, emergency	2, 806
		Overcrowding	18

Col. Louis F. Verdel, manager, stated that he had recently received a letter from the Medical Director of the United States Veterans' Administration, Washington, D. C., relative to the opinion of the central office in Washington regard-

ing commitment of patients admitted on voluntary status. In substance, the colonel explained that the Medical Director of the Veterans' Administration stated that if there was any conflict with the laws of the Veterans' Administration and the rules of the department of mental hygiene regarding commitment of voluntary patients, the Veterans' Administration rules and regulations, or laws, should be followed by the Northport Facility. In other words, the Medical Director stated in effect that voluntary patients were not to be committed regardless of whether they were considered suitable or not by the State medical inspectors unless the patient gave written notice requesting release or unless the family demanded the patient's release.

Colonel Verdel also asked the inspector why it was that patients admitted on a voluntary status could not be placed on convalescent status for short periods, say for 2 or 3 weeks at a time. He said he felt voluntary patients were being penalized in a measure; that, after all, it was advantageous to many voluntary cases to see whether or not they could make a satisfactory adjustment before actually and formally discharging a man. The manager made another point, too, that if voluntary patients could be placed on convalescent status for short periods it would obviate the necessity of going through the procedure of admitting them again if they were discharged first and then had to be readmitted.

The inspector was informed that at the present time the Northport Facility has 270 colored soldiers working as attendants. The colonel stated he had no direct discipline over these soldier attendants, that if one of them was involved in an altercation with a patient and was found guilty of mistreatment, he could only recommend that the soldier be court-martialed by the Army. The colonel realizes that soldier attendants are not the best type of attendants to attend mental patients but the facility has not been able to recruit enough civilian attendants.

With reference to the matter concerning commitment of voluntary patients who are not considered suitable for further care by the State medical inspectors, the colonel said he would get in touch with the central office of the New York State Department of Mental Hygiene just as soon as he has conferred with the New York attorney of the Veterans' Administration.

Since last inspection:	*Males*
New admissions received	247
New admissions remaining	239
Discharges	212
Deaths	21

Inspector saw 239 male patients who had been admitted since the last inspection. Each was interviewed and granted the privilege of the statute to make inquiries, comments, or complaints regarding their admission, care, and treatment. All were found suitable for continued care in their present status although several of the voluntary patients claimed that they had not understood the voluntary blank when they were admitted. However, these patients were shown a copy of the blank, and they all admitted having signed it. Inspector found the situation much better in this respect than at the time of the last inspection.

No complaints were received from these patients except the following:

No. 1 patient: Admitted November 29, 1944, judicial certification; age 28; diagnosis: Psychosis, unclassified. This patient was seen on ward 9. He complained that on February 10, 1945, at about 4:30 p. m., while in the hall on ward 9, two white attendants, Riley and Noble, took his clothes away from him, then took him upstairs after striking him. Inspector found that Attendant Riley was a white attendant but that Attendant Noble was a colored soldier attendant. Patient further claimed that Attendants Riley and Noble held his hands and that a third party struck him in the back as the two attendants first mentioned held his hands. Charge Attendant Walter Riley was interviewed and states that on the day mentioned the patient did become quite upset and resistive, but that none of the people mentioned struck the patient. Inspector was unable to prove that the patient had been mistreated.

No. 2 patient: Admitted January 8, 1945, voluntary status, later judicial certification; diagnosis: Dementia praecox, paranoid type. The patient is a sailor who, during the interview, was quite loud, boisterous, and threatening in manner. He immediately took off his trousers to show the inspector that someone, or somebody, was trying to prove that he was "queer," showing the stains on the inside of his sailor pants, saying that someone was monkeying with his sexual organs. He was very paranoid, stating he believed he was framed by his wife because she

is a "blow job" and wanted to make him one. Patient states there is nothing wrong with his mind and that he should be released from the hospital. It was seen that he was obviously psychotic and should be retained.

A list of patients seen is attached to this report.

ACCIDENTS AND INJURIES

Forty-three males were reported to the Department on Form 159, in accordance with General Order No. 12 as having sustained injuries since the last inspection. All such patients remaining at the hospital were seen, 37 patients seen by the inspector, and the circumstances reviewed by the inspector. The essential facts are as follows:

	Males		*Males*
Accidental	9	Improved	7
Impulsive act	11	Convalescent status	1
Altercation with patient	9	Discharged	3
Altercation with employee	4	Died	None
Unknown, or remaining cases	10	Transferred	2
Recovered	36		

In the following cases the reports were verified as set forth on Form 159:

Accidental

No. 1 patient: Between September 7 and November 14, 1944, narrowing of the bodies of the third and fifth dorsal vertebrae.

No. 2 patient: November 8, 1944, dislocation right fifth finger; small laceration under right eye and abrasion of tongue.

No. 3 patient: November 22, 1944, fracture distal and left radius.

No. 4 patient: December 3, 1944, laceration right eyebrow.

No. 5 patient: December 15, 1944, incomplete fracture proximal phalanx fifth left finger.

No. 6 patient: December 23, 1944, contusion with one-fourth inch laceration on palmar surface distal phalanx fifth finger right hand; fracture tip of distal phalanx fifth finger right hand.

No. 7 patient: January 10, 1945, Colles' fracture left wrist.

No. 8 patient: January 21, 1945, superficial laceration dorsum of nose; second-degree burns upper right arm/nd posterior right shoulder.

No. 9 patient: February 1, 1945, oblique fracture of shaft of fourth right metacarpal bone; recent or solid healed fracture of base of fifth right metacarpal bone.

Impulsive act

No. 1 patient: November 19, 1944, three lacerations right hand and thumb.

No. 2 patient: November 29, 1944, laceration one-half inch long back of right hand.

No. 3 patient: December 4, 1944, 1¾-inch laceration right lower forearm.

No. 4 patient: December 5, 1944, multiple small lacerations right and left hands; multiple small lacerations right and left hands; multiple superficial abrasions antreior surface of neck.

No. 5 patient: December 5, 1944, multiple small lacerations on dorsum and fingers of right hand.

No. 6 patient: December 14, 1944, laceration 3 inches long on lateral aspect right index finger; 1-inch laceration of right wrist.

No. 7 patient: December 20, 1944, lacerated wound of forehead.

No. 8 patient: December 23, 1944, contused wound bridge of nose.

No. 8 patient: January 1, 1945, laceration of left heel.

No. 9 patient: January 10, 1945, superficial lacerations of nose and cheek; no fractures.

No. 10 patient: January 23, 1945, fracture left zygomatic bone.

Altercation with patient

No. 1 patient: November 8, 1944, ¾-inch laceration of scalp back of left ear.

No. 2 patient: November 10, 1944, swelling and laceration of upper lip; swelling around right eye; small bruises about legs.

No. 3 patient: November 21, 1944, ¾-inch laceration bridge of nose.

No. 4 patient: November 23, 1944, 3½-inch discolorations on right thigh; one 2-inch discoloration at base of neck right side; one 1-inch discoloration right shoulder; one large discoloration posterior left chest; scattered bruises and scratches over body.

No. 5 patient: November 23, 1944, scratches on face.
No. 6 patient: December 16, 1944, lacerated wound of scalp.
No. 7 patient: December 27, 1944, laceration right eyebrow.
No. 8 patient: January 20, 1945, fracture of nasal bone.
No. 9 patient: January 28, 1945, fracture of first left metacarpal.

Altercation with employees

No. 1 patient: December 19, 1944, superficial laceration of lower lip; superficial abrasion of left upper eyelid.

No. 2 patient: December 27, 1944, ecchymosis about the right upper and lower eyelids.

No. 3 patient: January 25, 1945, ecchymosis into the skin over the left malar prominence and below left eye; abrasions of forehead and left side of face.

No. 4 patient: January 30, 1945, laceration of lower lip at right corner f mouth.

The unknown, or remaining cases, are noted as follows:

No. 1 patient: This patient had been very agitated, self-destructive, mute, resistive, and required tube-feeding and mechanical restraint. After receiving two electroshock treatments he became somewhat more cooperative. On November 26, 1944, it was reported to Capt. H. L. Gordon that this patient apparently had been injured. When X-ray was taken, old nearly healed fractures of the seventh, ninth, eleventh, and twelfth ribs on the right side were found. When interviewed, the patient would give no information regarding the injury. There had been no witnesses and inspector was unable to determine the cause. At this time the patient's injury appears to be recovered.

No. 2 patient: On November 14, 1944, at termination of patient's sixteenth electroshock treatment, patient complained of pain in the left shoulder and in the back of the neck. X-ray examination showed compressed fracture of the fourth dorsal vertebrae. Shoulder was negative. It appeared that this patient had received the injury during electroshock treatment. The patient had been passed by the electroshock board after all examinations had been made prior to treatment. Patient could not be seen as he was transferred to West Hill Sanitarium on January 24, 1945. At that time he was said to be recovered from his injury.

No. 3 patient: On November 13, 1944, patient was wandering around with other patients in the day room and was noted by an attendant to have a laceration on his upper right lip. Patient had not been seen fighting with anyone. In fact, he had been out of the pack just a short time and was overactive. A one-fourth inch long laceration was found on the right upper lip. This required one suture. When seen the injury was healed. Cause could not be exactly ascertained.

No. 4 patient: On November 27, 1944, a reddened area was discovered upon the left lower chest wall of this patient. The patient was unable to furnish any information regarding injury. X-ray was ordered and showed a fractured eleventh rib, left side. There were no witnesses to any injury. Patient had been frequently agitated and confused and had been observed by Lt. Col. Virgil B. Williams to frequently bang himself into the furniture and into the walls. He had also been given neutral wet-pack treatments. When seen, the injury was recovered and patient could give no further information regarding it.

No. 5 patient: On December 12, 1944, patient was seen to fall in the dining room of building 7. Patient was put in bed and X-ray examination showed a fracture of the neck of the right femur at the intertrochanteric line. When seen patient's right leg and hip were in a cast. The condition was improved. The patient himself, however, could give no details of the accident and was mute throughout the questioning.

No. 6 patient: On December 5, 1944, while in the pack room in building 11, patient complained to the physiotherapist that his hand hurt him. Examination showed swelling and deformity of the second right metacarpal area. X-ray examination showed fracture of head of second right metacarpal bone and fracture of middle phalanx of left fifth finger. Patient could not be seen by the inspector as he had been transferred to the veterans' hospital at Togus, Maine. Inspector was informed that patient's finger was improved when transfer was made.

No. 7 patient: On December 30, 1944, this patient complained of pain in his right chest. X-ray examination revealed fractures of the ninth and tenth right ribs, the eleventh left rib and avulsion of the tip of the spinous process of the sixth cervical vertebra. There were no signs of injury or ecchymosis on chest,

back, or neck. Patient had been receiving shock treatment which was discontinued. The X-ray man thought the fractures were from 6 to 8 weeks old when the X-ray was taken. It was said that the patient had been very overactive and in restraint continuously for months. He had cracked windowpanes with his head. He would not answer the inspector's questions and the exact manner of the injury could not be ascertained. When seen, patient's injuries were recovered.

No. 8 patient: On January 12, 1945, on ward 62 this patient was disturbed and assaultive. He was taken to building 11 where Lt. Col. B. Williams found a reddened area of lower anterior chest, a scratch on the patient's nose, bruises of both lower legs, and scratches about the patient's head. X-ray examination showed fractures of eighth, ninth, and tenth left and right ribs. The patient continued to be disturbed, assaultive, and required restraint. During the tussle before the patient was brought to building 11, soldier attendant, Fred Vaughn, had a tussle with the patient. A board was ordered by Col. Louis F. Verdel to investigate this accident and soldier attendants Wesley and Vaughn were found guilty of mistreating the patient. It was said that soldier attendant Vaughn probably struck the patient also. As noted before in this report, in such an instance Colonel Verdel, the manager, can only recommend that a soldier be court-martialed for mistreating the patient. The colonel has no direct disciplinary authority over the soldier attendants. When patient was seen, all injuries were recovered.

No. 9 patient: On November 14, 1945, the nurse on ward 11 found out that his patient had broken through the door of the day room and jumped off the porch of ward 11B south to the ground. The right ankle was swollen and deformed. X-ray showed a fracture of the right os calcis. This was attended to properly. Patient could not be seen because he had been transferred previously to the Veterans' Administration facility, Kingsbridge Road, Bronx. Inspector was informed that the fracture was improved at the time of the transfer.

No. 10 patient: On January 27, 1945, when the patients were being assembled to the main dining room for breakfast, soldier attendant, Private Bryson, reported that the patient had a swollen left cheek. Patient was questioned and stated he had a toothache. He was sent to the dental office and X-ray examination showed a fracture at the angle of the mandible, left side. When interviewed, patient said he had had no injury. The exact cause of the injury could not be discovered. The injury was recovered when patient was seen by the inspector. Board investigation was appointed by the manager, Col. Louis F. Verdel, and inspector perused the board's report. The report stated "unable to come to any conclusion as to how and when this injury occurred."

SUICIDES OR SUICIDAL ATTEMPTS

One male patient attempted suicide since the last inspection. A résumé of the case follows:

He was admitted August 9, 1944, age 27, dementia praecox, catatonic type. Date of attempted suicide November 29, 1944. About 8:15 a. m., on the date mentioned, while in the hallway sweeping, patient dropped the push broom, ran over to the window, thrust his hand through one of the panes and immediately picked up a piece of glass and started cutting his throat with the glass. Attendant Parsons, who was in the hallway supervising other patients, came right to the scene, preventing further injuries. When asked if he had tried to kill himself at the time, patient said, "Yes." The resulting injuries were superficial wounds of the forehead, chest, abdomen, neck, and hands. When seen on February 17, 1945, by the inspector, all of patient's wounds were recovered.

SUDDEN DEATHS

None.

ESCAPES

Eight male patients were reported to the Department on Form 159 as having escaped since the last inspection. The essential facts regarding these patients are as follows:

	Male		*Male*
Returned from escape	3	Died	None
On convalescent status	2	Located, not returned	None
Discharged	1	Not located	2

The patients who had been returned to the institution were interviewed and the facts as reported on Form 159 were verified in the following cases:

No. 1 patient escaped November 10, 1944; returned.

No. 2 patient escaped December 10, 1944; returned January 1, 1945.

No. 3 patient escaped December 18, 1944; returned.

The following is a list of the patients who could not be seen by the inspector:

No. 1 patient escaped November 22, 1944; discharged November 30, 1944.

No. 2 patient escaped November 25, 1944; not located.

No. 3 patient escaped December 1, 1944; not located.

No. 4 patient escaped December 2, 1944; convalescent status January 1, 1945.

No. 5 patient escaped December 10, 1944; convalescent status February 14, 1945.

Numerous supplemental letters were received concerning patients who had previously eloped, but the dates of elopement were not given regarding each patient. Inspector was unable to unravel the details of these letters.

SPECIAL INVESTIGATIONS AND INTERVIEWS

No. 1 patient: Admitted June 7, 1943; judicial commitment; age 29. Diagnosis: Dementia praecox, paranoid type. Attorney at law by occupation. This patient asked to see the inspector. The patient claimed that he was sane and that he was supposed to have a hearing on a writ of habeas corpus at the Nassau County Courthouse on February 20, 1945. He is an ex-soldier of World War II.

He stated he believed he was sent to the Veterans' Administration facility at Northport from the Tilton General Army Hospital at Fort Dix, N. J., for reasons other than his need for mental treatment. He stated he assumed the Army did not like his personality. He referred to an Army sergeant making an insulting remark to him, says he can't remember the remark now. He stated that maybe the Army didn't like the way he looked and had him sent to Northport. Although the patient was well oriented, was agreeable and pleasant during the interview, he impressed the inspector as distinctly paranoid and in the inspector's opinion he should be retained in his present status.

No. 2 patient: This patient was seen in response to a letter that he wrote to the department of mental hygiene on November 8, 1944. The present inspector had seen this patient at the time of the last inspection of Northport Facility on November 20, 1944. Patient was admitted to the Veterans' Administration facility at Northport on October 12, 1939, by voluntary application. He was judicially committed October 24, 1939. Present age is 42. Patient has no guardian or committee appointed. Diagnosis: Dementia praecox, paranoid type.

Patient has the same complaints about his mail not being sent out from the facility. He stated in his letter, "I am in a desperate situation here, being incarcerated, being persecuted, being held here incommunicado," and so forth, and so forth. Patient stated he was not given a fair hearing in court when he had his writ hearing. He also stated that he was still getting electric contacts which affected his body and his well-being. It was easily seen that this patient was distinctly and obviously psychotic. His complaints regarding his mail are not held valid by the inspector and he should be retained in the hospital.

No. 3 patient: This patient asked to see the inspector. Also on December 24, 1944, he had written a letter to Gov. Thomas E. Dewey, complaining in effect that he was held illegally at the Veterans' Administration facility, Northport, and making complaints about the inspector, the staff of the facility, and others interfering with his mail. He even accused the present inspector of stealing his mail.

This patient was admitted to the Veterans' Administration Facility, Northport, on December 20, 1943, by judicial commitment. Diagnosis: Paranoid condition. Age 43. Patient has no guardian or committee appointed. Government registration No. 6786.

When seen on February 17, 1945, patient had a large stack of papers to which he constantly referred. He stated he knew he was illegally held at the facility. He stated he had been told that his record, if taken to court, would, of itself, prove that he has no business in the facility. He stated the only reason his letter of December 24, 1944, got through to Governor Dewey was the fact that he sneaked the letter out. He stated the letter he sent to the commissioner on December 14, 1944, was not, insofar as he knows, ever received by the commissioner because he never got an answer to it.

Patient states he got an original legal paper allowing him to have a hearing on a writ of habeas corpus from Judge Cortland A. Johnson on February 5,

1945; further, that the envelope was addressed to him, the patient, and not to Colonel Verdel, the manager. This writ was returnable on February 14, 1945, before Justice of the Supreme Court Stoddard at Riverhead, Long Island. Patient claimed he mentioned having received this writ to Captain Dancik. He stated he had not sent the writ over to the office of the manager, Colonel Verdel, because he could not get any stationery with which to write to Captain Dancik and asked the captain to tell Colonel Verdel about it, however. Finally, patient states he wrote out a copy of the writ on brown paper and also made out a subpena duces tecum and sent this, together with a copy of the writ, to Colonel Verdel on or about February 10, 1945. He still retained the original writ, however. As of February 14, 1945, patient said that inasmuch as no move had been made to take him to court, he sent the original writ over to Colonel Verdel with a written notice. As a matter of fact, on the morning of February 15, 1945, the manager, Colonel Verdel, showed the inspector the original writ with the patient's letter accompanying it. The manager remarked he did not understand why the judge sent the original writ directly to the patient. Anyway, Colonel Verdel got in touch with the judge and the writ was further set for hearing on Tuesday, February 20, 1945.

As a result of all this, the patient stated he was sure that Colonel Verdel had known all along about the original writ because Captain Dancik must have talked it over with him. The inspector's opinion is that this patient was trying to embarrass the hospital and Colonel Verdel by withholding the writ.

After the inspector talked with the patient, he went to the colonel's office and was shown the copy of the writ which the patient made on brown paper and sent to the manager. However, this copy was not noticed particularly by either Colonel Verdel or the writer when the writer talked to Colonel Verdel on February 15, 1945, when the manager mentioned that he had received the original writ from the patient. The patient, in other words, stated he was going to show, in court, that Colonel Verdel purposely did not take him to court on the 15th. He said he also believed the manager had opened the patient's letter to Judge Johnson requesting the writ. Patient further stated his mail to outside people was not sent in some instances and that in other instances "covering letters" were written by Colonel Verdel. This is true, as Colonel Verdel remarked that it was the practice of the Veterans' Administrative facility, Northport, to write letters of transmittal when patients wrote to judges and other prominent officials.

This patient already had one hearing on a writ of habeas corpus on March 29, 1944, before Supreme Court Justice Cuff. The patient reported to the inspector that Justice Cuff reserved decision during the hearing, but later in the day remanded the patient back to the facility. Patient complained that not a single letter of his, written to lawyers or counsel, had been sent out.

He complained that the inmates—that is, the patients—are being beaten by civilian attendants. He said that on September 17, 1944, at about 8 a. m., he saw a night attendant—refuses to name the attendant—kick a patient in the stomach about a half dozen times. He also said that soldier-attendant Pvt. Guy Smith saw the night attendant kick the patient also. He added that he tried to report this case and two others of mistreatment of patients to Colonel Verdel, the manager, but that Captain Hawkes refused to put him in touch with Colonel Verdel. Patient also accused Captain Hawkes of stealing part of patient's Army kit and removing it from the facility. Patient further claimed that Attendant Laszewska, on ward 3, on or about December 5, 1944, beat a patient while three other soldier-attendants held the patient helpless. Patient refuses to name the three soldier-attandants. He further stated that Attendant Laszewska threatened twice to beat him, the patient, up. Throughout the hour interview with this patient, he was seen to be distinctly paranoid, although well oriented. He has no insight at all into his mental condition, stating he had never had anything wrong with him mentally.

Patient further complained that Captain Hawkes neglected treatment of an infected foot of a patient on ward 7 on or about April 1, 1944. In addition, the patient complained that another patient was very sick on or about September 1944, only to be ignored by Captain Hawkes. He says he knew this patient was running a high fever because he checked his temperature with his hand. It is the inspector's opinion that this patient is obviously and definitely psychotic and that he is, furthermore, potentially dangerous, and therefore should be kept in the hospital.

No. 4 patient: This patient asked to see the inspector as inspector was going through building 11. He was loud, noisy, and protested that his mail was not sent out. Patient was admitted September 11, 1942, by transfer from the Rock-

land State Hospital. Mental diagnosis: Manic-depressive, manic type. He has a guardian, his wife. Lt. Col. Virgil B. Williams, chief of the acute service, ward 11, was along when the inspector saw the patient. Colonel Williams explained to the inspector that patient's mail was sent out unless it was obscene, illegible, or otherwise objectionable, in which case it was sent to the patient's guardian or committee; that, at any rate, the rules of the Veterans' Administration with respect to patient's mail were being closely followed. The patient handed the inspector a letter to Reporter Deutsch, who writes for the newspaper PM, and asked him to sent it to Deutsch. Inspector turned this letter over to Colonel Williams and asked him to take proper steps about it. The reporter referred to fairly recently had written a series of articles about the Veterans' Administration facility, Northport, in the newspaper PM and patient said he wanted to berate Deutsch for certain statements he had made concerning the facility.

EMPLOYEES

In institution: Male, 294; female, 186; total, 480.
On ward duty: Male, 134; female, 19; total, 153.
Vacancies, ward service: Male, 96; female, 57; total, 153.
Vacancies, elsewhere: Male, 62; female, 76; total, 138.
Graduate nurses, wards: Male, 1; female, 41; total, 42.
Graduate nurses, elsewhere: None.

As noted before, at the present time the facility has 270 colored soldier attendants. These men are under the direct authority of three United States Army officers. The manager, Colonel Verdel, has no direct disciplinary authority over them. The colonel admitted that these soldier attendants were causing difficulty, principally because they did not understand how to handle mental patients and also because they did not get along well with many of the patients. The colonel is trying to have all soldier attendants who have been court-martialed and punished relieved of further duty at the facility.

TRAINING SCHOOLS FOR NURSES

The facility has no school for nurses.

OCCUPATIONAL THERAPY

Personnel: Male, 7; female, 5; total, 12 (two soldiers also work in the occupational thereapy department as instructors).

Patients in occupational therapy: Male 1,676 (352 actually in occupational therapy work and 1,323 in other occupational therapy projects).

Patients in physical training: Calisthenics, male, 1,621; swimming, male, 1,959; medicine ball, male, 762; water polo, male, 1,189.

The occupational therapy building was described completely in the last report. Inspector's opinion is that it continues to function well and is reaching a goodly number of patients.

RESTRAINT AND SECLUSION

Patients in restraint: Male, 19. There were 11 patients in camisole and 8 patients in sheet restraint on the day of inspection. The facility has two large pack rooms in building 11 which are used constantly. The inspector was informed that the facility avoids mechanical restraint as much as possible.

GENERAL HEALTH

Acute medical cases: Male, 38.
Acute surgical cases: Male, 29.
Cases of pulmonary tuberculosis: Male, 53.
Cases of contagious disease: None.
Total bed cases: Male, 40.
The cases of pulmonary tuberculosis are isolated and treated in building 8.

Shock therapy

Insulin shock: None.
Electroshock: Male, 33.
The electroshock treatment is being done by Captain Kashe and Captain Gordon. Treatment is now being done in building 61.

FOOD SERVICE

All food is prepared in one large central kitchen. Most of the patients eat in two large dining rooms adjacent to the kitchen. The menus are made up by Mrs. A. E. Griffith, chief dietitian, and she has three staff dietitians under her supervision. One staff dietitian has been added since the last inspection and there is now one vacancy for another staff dietitian. Besides the dining rooms in the same building as the large central kitchen, there are also dining rooms in patients' buildings 2, 6, 7, 8, 9, and 11. The admission wards also have their own dining rooms. Food is sent to these dining rooms in electrically heated food carts. The food is put into covered metal containers before being placed into the food carts. All of the dining rooms seen were very clean. The food appeared to be good in quality and sufficient in amount. As noted before, all staff members, employees, and patients get the same food at this institution.

The central kitchen was inspected and found to be clean. Menu for the midday meal on February 16, 1945, was as follows: Fried fish, mashed potatoes, stewed corn, string beans, bread and butter, coffee and milk, and toasted almond ice cream. Usually the patients' band of 10 pieces plays at the midday meal. The central kitchen seems to the inspector to be rather small and rather far removed from some of the dining rooms in the patients' buildings to which food has to be taken a long way by food carts; also the fact that two sittings in each main patients' dining room are necessary for each meal. The milk used at the facility is purchased from Borden's. The food is served in the central dining rooms from heated food carts, which are pushed right down the aisles between the tables.

The tables were seen to have tablecloths and the backs of the chairs had white covers. The dish-washing equipment was inspected and found to be functioning well. Dishes and silverware were seen to be clean.

In the infirmary in building 2 food is taken to the ward in electrically heated food carts and served by tray at the bedside.

The menu for the week of February 12, 1945, is attached.

SOCIAL SERVICE

Personnel, female, two.

One social worker has been added since the last inspection. There are two vacancies for social workers. Most of the work done by this department is done at the hospital. It consists of interviewing patients preparatory to their release. Preconvalescent status investigations are done by workers from the regional office at 26 West Twenty-fifth Street, New York City. No convalescent-status clinics are held.

INSPECTION

A number of the patients' buildings were visited during the course of the inspector's visit, including building 2 housing the infirmary wards and admission wards; the building housing the central kitchen and dining rooms; the recreational building; the research unit; the electro-shock-treatment unit; laundry; clinical laboratory; X-ray department; dental department; pharmacy; patients' and staff library; diagnostic clinics.

The kitchen and central dining rooms have been described.

The housekeeping in building 2 housing the infirmary ward and the admission wards was good. Toilets were clean. Bedding was adequate. There is some overcrowding but patients appear to be receiving good care.

The clinical laboratory is located in building 2 also. On the day of inspection one technician was on sick leave and a temporary technician from the Veterans' Administration facility, Bronx, was replacing her. There are two other clinical laboratory technicians. Also in building 2 is a small laboratory where tissues are cut and stained for the research unit.

The so-called research unit is located in the basement of building 6. This unit was established in August 1941 and is supposed to conduct research for all the Veterans' Administration neuropsychiatric hospitals. Lt. Col. James H. Huddleston is director, and Maj. William J. Turner is in charge of the electroencephalographic work and helps with the teaching. There is one tissue technician who, as noted, works in the small laboratory in building 2. At present there is no fully trained biochemist. There is one soldier chemist who is helping out at this time. There are two vacancies for biochemists. The unit has, at present, one statistician, one secretary, and one stenographer. A course in electro-encephalography for three physician trainees has just been finished.

Colonel Huddleston explained that once a month the unit conducted a staff meeting and that once a week he and Major Turner attended the general staff

meetings and gave short talks ranging from 15 to 45 minutes. The research unit assists with the electro-shock treatment by way of advising and also by way of doing pretreatment electro-encephalographs on candidates for the electro-shock treatment. It was said that about 2 percent of the candidates had been thrown out before treatment because of abnormal electro-encephalographic tracings.

The X-ray department is also in building 2. One physician reads the plates and has charge of the department as well as supervising the work of the clinical laboratory. Routine chest films are not done on admission. The physician in charge of the X-ray department explained that the facility usually obtained the Army chest films done on the soldiers when they were taken into the Army but chest films are done when indicated by physical examination or by suspicious history. One X-ray technician was working at the time of the inspection. The X-ray equipment is G. E., is soundproof, consists of an X-ray machine for regular 14 by 17 films, a fluoroscope with tilting table as well as an apparatus for taking 35 mm. chest films. The X-ray room is protected by lead walls and doors. Dark room is quite satisfactory.

Electrocardiograms are done in the X-ray department by Maj. Angelo S. Naples. The electrocardiogram is an old Victor battery type and inspector was informed it does not work too satisfactorily.

The dental department is also in building 2. There are four units together with dental X-ray. There is one chief dentist, one assistant dentist, one dentist, one dental hygienist and one assistant dental hygienist. Adjacent to the dental treatment room there is a small mechanical dental laboratory where part of the work is done on dentures after which the dentures are sent for completion to the Veterans' Administration facility, Bronx, New York City.

Pharmacy is also in building 2 and appeared to be well equipped.

Patients' library is located in building 2 and there are three librarians. Books are taken to the various wards also. The medical library is adjacent to the patients' library and contains about 850 textbooks. Approximately 50 medical journals are subscribed to by the facility.

Major Naples now has charge of the eye, ear, nose, and throat clinic room in building 2. All acute eye cases and eye injuries are brought to this room for initial examination and treatment. Refraction for glasses is done and glasses are fitted also. The facility formerly had one physician assigned to this, but he has since left the facility and so the services of a full-time physician in the eye, ear, nose, and throat clinic are not possible at the present time. The eye, ear, nose, and throat room could use some special pliers and screw drivers for repairing eyeglass frames.

Inspector also visited the autopsy room and morgue which is in the basement of building 2. Equipment seemed to be adequate with the exception that there were only three refrigerators for cadavers. Dr. Triolo, who has charge of the autopsies, informed the inspector that he believed the facility planned to put in more refrigerators for bodies.

The recreational hall was inspected February 16. This contains an auditorium for the showing of movies; also pool tables and bowling alleys.

The laundry was inspected. The building seems to be very small considering the size of the hospital at the present time. All the machinery is located on one floor. At present there are about 30 employees and 65 patients working in the laundry. The laundry manager stated that about 450,000 pieces of laundry a week are done. The quality of the work seemed excellent to the inspector. The laundry manager explained it was necessary to work several nights a week in order to keep up with the work. Machinery seemed to be in condition. The manager informed the inspector that the very latest methods were used. It is completely equipped with CO_2 foam-type fire extinguishers.

Electro-shock treatment unit is housed in a room in building 61. This room is on the second floor. Treatment is done on regular wooden shock-treatment table which is flat. Sandbags are used on the back. Inspector was informed by Major Naples, who accompanied him, that some of the patients are being given fumarate, a new compound which is supposed to have something to do with the metabolism of the sugar in the brain. The results, as yet, are inconclusive, apparently. The shock treatment is carried on by Captains Gordon and Kashe.

Inspector also saw a small luncheonette and canteen, as it is called, which is located in the basement of building 65. This is frequented mostly by patients. There is a soda fountain and sandwiches are served. Tobacco is sold also. There are no recreational facilities for the employees and there is no lounge or recreation room for the employees at this facility.

FIRE PREVENTION

Throughout the tour of the various buildings, inspector noticed there were standpipes and hose on each floor. Fire extinguishers are located at strategic places. These are filled once a year. They were marked as having been last refilled in the summer and fall of 1944.

REPORT OF NEW IMPROVEMENTS

More office space is being provided for the clinical director. Supply office has been moved from the administration building to building 18. Two porches in building 63 have been enclosed, giving space for 48 more beds.

REMARKS

The barbering for the patients is done by three regular civil-service barbers, assisted by five of the assigned personnel. Attendants on the wards help also. Barbering is done on the wards with the exception of some stationary chairs which are set aside in separate rooms. Shaving is done three times a week. Hair cuts are done as often as possible.

Diagnostic stay meetings are held on Monday, Wednesday, and Friday in the morning. Once a month on Saturday afternoon scientific staff meetings are held. The facility has gotten up a weekly calendar of recreational and other facilities, a copy of which is enclosed.

Inspection was completed at 4 p. m., on February 17, 1945.

Inspector wishes to express his appreciation to Col. Louis F. Verdel, manager; Col. H. E. Foster, clinical director, and to Maj. A. S. Naples for the courtesy shown during the visit. Major Naples was especially helpful and also accompanied the inspector during the tour of inspection. Inspector wishes to state he received good cooperation from the officials of the facility.

Respectfully submitted.

B. B. YOUNG, M. D.,
Acting Medical Director.

(Record, pt. 3, p. 1311.)

Dr. (Colonel) Verdel in his testimony before the committee made two recommendations for the consideration of the committee:

1. I thought it would be a good idea to get a complete and full and honest picture as to veterans' hospitals as a whole to appoint a committee of doctors—I suggested one from the Army and one from the Navy and one of the doctors from the New York State service, and let them go there and made a thorough survey of the hospital. They will be men that are capable of making surveys. They will know what to look for. They will be able to give the committee some concrete evidence. They will know about abuses of patients. (Record, pt. 3, p. 1334.)

2. Another thing I think would help these mental hospitals is to have full-time chaplains. (Record, pt. 3, p. 1335.)

Mr. Harry Stansfield

Mr. Harry Stansfield, an investigator for the Veterans' Administration, was called before the committee to testify of his findings after he had made an investigation at Northport, Long Island, N. Y. Without trying to minimize in any way the mistreatment of veterans which he found, Mr. Stansfield testified in part as follows:

Early this year certain under-cover investigators were assigned to the Northport facility and went there and secured positions as attendants.

During the course of their employment they submitted written reports to central office of the various incidents which they observed. * * * About February 22 I was ordered to New York to follow up with the under-cover investigation, and our method being to take the incidents reported by the under-cover men, then bring in the witnesses and the principals and secure their testimony under oath. * * * (Record, pt. 3, p. 1337.)

I was at Northport approximately 2 months on this investigation. I had considerable trouble with the Negro soldiers there in refusing to testify, and after they were forced to testify, then they would refuse to sign their statements.

None of the Negro soldiers would ever admit that they were involved in these episodes. * * *

As a result of this investigation, there were approximately 13 colored soldiers who were court-martialed and 7 civilian attendants who were dismissed from duty immediately as soon as we got sufficient evidence. (Record, pt. 3, p. 1338.)

And now as to individual cases, Mr. Stansfield reported to the committee without using the name of the patient:

Patient A: On January 21 Attendant Robert B. Leisenger struck this patient on the back of the neck with his open hand and pushed him into the hall in the day room and called him obscene names and threatened to beat hell out of him if he did not stay in the day room. * * *

This is something that was seen by the undercover investigator, the man working as an attendant, which he reported to me, and then I took the testimony of these attendants that were charged with the offense. * * *

Attendant Emmett J. Griffin also testified that he had seen Head Attendant Leisenger—also Attendant Griffin commit these abuses and confirmed that in his testimony—and he also confirmed the fact that Attendant Leisenger had abused the patients by striking them and kicking them on the shins. * * *

Both of those attendants have been discharged and they are among the attendants whose names have been given to the United States attorney for prosecution. * * *

On the morning of November 23, 1944, patients B and C were found to have some discolorations about their bodies, necks, and shoulders, left chest, and one of the patients was crying. The other patient had a cut on his left cheek. (Record, pt. 3, p. 1339.)

The board of investigation found soldier attendants—the colored soldier attendants who were on duty. One had claimed that these two patients had been in altercation with each other and caused the injury and denied that any of the attendants caused the injuries.

The evidence was not developed to the point where you could definitely say or charge these colored soldiers with this abuse, but it was indicated that these patients had refused to get up that morning, or they had had some difficulty in getting them up, and that the soldier attendants who were on duty in that ward had dumped them out of bed, or had apparently abused them or mistreated them. But the evidence was not sufficiently conclusive to warrant court martial. * * *

Might I explain here? At the time I commenced my investigation all of the soldiers were colored soldiers, and it was during the investigation that I recommended that the colored soldiers be removed immediately, and then they partially removed them as they were able to replace them; but these abuses were while all the soldiers were colored soldiers. * * *

They sent a colonel out there to investigate the matter, and he took the testimony of Colonel Verdel and my own testimony as to my observations, and he intimated at the time that he did not have enough white soldiers to replace them.

So, later on, I came on down to Washington and had a conference with General Hines, and he took it up with the War Department, and they were able to march in—they were able to find some white soldiers to put in there, but my understanding is they have not yet found enough to replace with white contingents. * * *

As I say, in this particular case we were unable to get sufficient evidence to convict, but the recommendation was made that these two soldiers who were suspended should be removed from the station. * * *

I was convinced in my own mind that these soldiers were responsible for the injuries.

In the case of patient D the undercover investigator saw attendant beating patient in the shower room for having soiled himself. * * * (Record, pt. 3, p. 1340.)

Of course, I followed the under-cover investigator. The matter was brought to the attention of the commanding officer, who requested that "the soldier be removed from the facility. * * *

He was one of those who were court-martialed.

Next is patient E, which was prior to the time we sent undercover investigators there, and it was also investigated by the station board, which was unable to get sufficient evidence to show the true facts.

It might be explained that these incidents which were investigated by the station board occurred several months prior to the time I arrived on the station, and obviously, it was difficult to get much evidence, 3, 4, or 5 months later.

As I say, the matter was investigated at the time it happened, but the investigation was made by doctors on the staff, and of course, they are not trained in investigation work and were unable to get the facts, in many instances. * * * (Record, pt. 3, p. 1341.)

As long as I have been in the Veterans' Administration I have always found there has been some abuse, perhaps not as widespread as it has been in the last couple of years, and we got many of these station board reports, on which we conducted further investigation." * * *

They are confined largely to NP hospitals, although we have made the investigation in other cases as to whether a patient was injured as a result of negligence.

If he is not a mental patient he is usually able to take care of himself and tell what happened, so we do not get those who are not mental cases. * * *

I said we had other cases of these board investigations. I do not know of any cases than those I have personally investigated, but I know what the practice is, of sending in for review, the station board reports, to see whether the evidence had been properly developed or whether it was necessary to further develop it in order to charge an employee.

We have conducted those in the past. * * * (Record, pt. 3, p. 1342.)

I might explain, whenever an injury or accident—it does not necessarily have to be abuse—when any injury or action happens at a hospital, the regulations require that a report be made to the Medical Director, and if it was serious enough, a board of doctors was appointed at the station to investigate, take testimony.

That report is sent into Washington to the Medical Director, and in turn, it is referred to the Investigation Division for review to determine whether the evidence has been sufficiently developed and, if not, we make a recommendation that central office investigate it.

If we develop a case of where an attendant has been guilty of mistreatment, we recommend that charges be preferred against this attendant.

Then a committee is appointed to consider those charges and the employee's reply to those charges.

If they think the evidence is sufficient, they will then take action to remove him, or reprimand him, or to administer such punishment as they think warranted. * * *

The patient E on August 5, 1944, was taken by two colored soldiers, from the back room. A short while later the patient was found in the shower room with his eyes blackened and closed and discolored and with various lacerations about the head.

We were not able to develop evidence to show conclusively that these two particular soldiers inflicted these injuries but they were explained now in no other manner. (Record, pt. 3, p. 1343.)

That patient received a fracture of the tip of the nasal bone and fractures of the fifth and eleventh right ribs.

Those soldiers were removed from the station. As I say, there was not sufficient evidence to charge any particular soldier. I think there were four soldiers on duty on that ward on that day at that time. It was impossible to determine which ones of the soldiers had beaten this patient, even assuming he had been beaten.

I was convinced in my own mind he had been beaten. * * *

Patient F was abused on numerous occasions. The undercover investigator on January 28, 1945, witnessed Attendant Emmett J. Griffin kick this patient on the shin and beat him about the head with his fists.

Another undercover investigator reported on the same date, later in the day, colored soldier Pvt. Charles Sanders kicked this patient in the shins and hit him on the face while they were putting the restraining sheet on him.

Pvt. Jerome Hamilton was present and witnessed this incident, but each of them denied this allegation. * * *

He was not the assaultive or combative patient, but he was resistant. They had to tube-feed him; he would not eat. He would resist everything done for him. He would spend his time standing by the door trying to escape. Every opportunity that the door was opened he would run down the hall and try to get out. I assume many of the attendants lost patience with him for trying to keep him out of the way and that was the cause of these abuses. * * * (Record, pt. 3, p. 1344.)

The same patient on January 30, 1945, while giving him a bath, this same attendant, Griffin, endeavored to hold this patient in a shower room, and sometime later the undercover man saw the patient coming out of the shower room rubbing his jaw which was slightly swollen.

There was no other witness, and I was unable to secure Attendant Griffin's confession to all of these things. * * *

My only explanation for that is that these things do not occur in the presence of doctors or nurses. These attendants are very careful about the time and the manner in which they inflict this punishment.

Usually, they do not do it in front of other patients. If they have something against the patient, they usually take him in a shower room or dressing room and lock the door.

And usually, it has been my experience, they try not to leave any marks. They will punch him with an elbow not to leave any marks.

So, it is not strange when you know the conditions that the doctors and nurses do not know it. * * *

The code is, they will not "peach" on each other. They do not want it known—they do not want to be known as a stool pigeon. And they always make the stories that the injury has been inflicted by another patient.

We have had them report that patient was injured in a fight with another patient, and we have found it was inflicted by an attendant. But these are the conditions with which we have to cope.

This same patient on January 30, the same day—about noon—it was necessary to put this patient in restraint to tube-feed him, which was necessary for every meal. He refused to eat.

Private Sanders, a colored soldier, used a towel to choke the patient into sufficient submission, and was urged to do so by Private Hamilton, anotehr colored soldier.

Another report, on January 31, 1945, at 9:10 a. m., attendant pushed patient into a dormitory and locked him in to keep him out of the way while changing linen; the patient got away—he broke away and ran to the door, where Griffin overtook him and threw him to the floor.

While he was on the floor, Griffin kicked him twice on the left shin, causing bruising to his shin.

Mr. Griffin then produced from his pocket a hand towel and forced the patient to a bed.

On January 31, 1945, when attending to him this patient put up a struggle and at that time Attendant Griffin choked the patient with a towel into submission. * * * (Record, pt. 3, pp. 1345–1346.)

* * * In that case, it was the case of abuse while I was there on the station making an investigation, in which the patient was severely beaten with a rubber hose.

As I stated before, as usual in those cases, they took him in a shower room and locked the door, and it was a couple of days later—he apparently was a patient who some days was in good condition and the next day would not be able to tell you anything.

A couple of days later he told the nurse and showed the bruises and marks on his body, at which time he said that Private Carey had beaten him with a rubber hose.

The only other evidence we have was that the nurse had gone to the door and found it locked and opened it up and found these two soldiers sitting on the floor. They claimed they had attempted to change his clothing and he had put up a flight, but I saw the bruises on this patient and it was evident he had been beaten with a rubber hose. * * *

I felt that Colonel Verdel was cooperating in every possible way with me; he was equally as anxious as I was to develop the evidence; he came to me many times with information he thought would be of help to me in developing these facts and did everything possible. * * * (Record, pt. 3, pp. 1346–1347.)

Well, of course the soldiers employed, the colored soldiers, were not on the high mental level of these conscientious objectors, and you could not get any reasoning out of them, one way or the other, or what they thought about it. They merely denied that they ever mistreated them; would not admit anything.

In fact, most of them refused to testify until they were told to do so by the commanding officer. * * * (Record, pt. 3, p. 1349.)

The facts have been presented to the United States attorney, and he has been told the records would be made available at any time he wanted them. (Record, pt. 3, p. 1350.)

Mr. Stansfield was then asked to put into the record the names of all white attendants who were assigned to duty at Northport, Long

Island, N. Y., and afterward dismissed from the service, and he replied as follows:

Robert B. Lysinger, Emmett J. Griffin, Edward J. Schuh, Henry Stelljes, George F. Wolzworth, William Matson, and Eric Kastick. (Record, pt. 3, p. 1351.)

Mr. Stansfield has brought to the committee evidence of mistreatment of patients at the Northport facility which must, in some way, be corrected for the future care and supervision of mental patients in Veterans' Administration hospitals throughout the United States. The facts revealed by Mr. Stansfield's testimony, and the under-cover men who preceded him, are most damaging to the morale of veterans throughout the United States who may, in the future, be patients in these hospitals. It is felt that all measures possible have been taken in regard to the incidents which have been recited, but precaution must be taken in the future to see that no abuses are inflicted upon the mental cases confined to Veterans' Administration hospitals throughout this country.

Special medical advisory group

The committee called as witnesses some outstanding physicians and surgeons from different parts of the United States. These gentlemen had been contacted by this committee and asked to testify and prepare a statement for the benefit of this committee some weeks prior to the time their testimony was introduced. The committee had the advantage of the testimony of:

Dr. George Morris Piersol, Philadelphia, Pa., an outstanding medical man of that city; professor of medicine, Graduate School of Medicine, University of Pennsylvania; director of the center for instruction and research in physical medicine, University of Pennsylvania; medical director, Bell Telephone Co. of Pennsylvania; and editor in chief, the Encyclopedia of Medicine.

Dr. Max Cutler, Chicago, Ill., director, Michael Reese Hospital, Chicago; a former instructor in pathology, Cornell Medical School and Memorial Hospital, New York; former director, New York City Cancer Institute; associate in surgery, Northwestern University, Chicago, Ill.; past president, American Association for Study of Neoplastic Diseases.

Dr. Malcolm T. MacEachern, Chicago, Ill., associate director and chairman, administration board, American College of Surgeons; professor of hospital administration; associate professor of medicine, Northwestern University; former general superintendent, Vancouver General Hospital, Vancouver, British Columbia; member, committee on hospitals and Memorial Commission Physical Rehabilitation; National Defense Advisory Board; advisory board of American Dietetic Association; advisory council, Association of Medical Social Workers.

Dr. Roy D. Adams, Washington, D. C., clinical professor of medicine, Georgetown University School of Medicine.

Dr. William F. Lorenz, Madison, Wis., professor of psychiatry, University of Wisconsin Medical School; and chairman of the Wisconsin State Board of Mental Hygiene.

Dr. George Morris Piersol

Dr. George Morris Piersol, of Philadelphia, Pa., in his testimony before this committee stated, in part, as follows:

The impression has been gained that from the Medical Director and the heads of the divisions down, with few exceptions, the medical officers of the Veterans' Administration are an earnest, diligent, conscientious, well-trained group of physicians who have been trying to practice satisfactory medicine in the Veterans' Administration in spite of the many handicaps and restrictions under which they have had to work. It is a tribute to their enthusiasm for medicine and interest in the Administration that under existing circumstances they have accomplished so much and taken such good care of the sick and injured veterans entrusted to them. * * * (Record, pt. 5, p. 1846.)

Every group with which I have been connected that has ever investigated the medical activities of the Veterans' Administration is in agreement that the medical services given to our veterans could be improved and that the medical and hospital functions of the Administration are in need of reorganization. The way in which the reorganization and improvement can be effected has been set forth in detail in a special report entitled "Proposed Basic Changes in the Medical Service of the Veterans' Administration," submitted to the Administrator of Veterans' Affairs by the special advisory group on May 17, 1945.

This report deals with certain defects that are inherent in the organization of the Veterans' Administration due, in large measure, to the laws and regulations under which the medical department of the Veterans' Administration operates. Until certain faults in the present set-up are eliminated it is doubtful whether any group of physicians can render to our veterans the first-class medical care to which they are entitled.

The changes recommended should start with the central office organization. At present the Medical Director of the Veterans' Administration, who is its chief medical officer, is not even an Assistant Administrator. The Assistant Administrator who, along with other responsibilities, represents medicine is a layman through whom the Medical Director reports to the Administrator.

At present, therefore, the Medical Director is not a member of the policy-making group of the Veterans' Administration which is composed of the Administrator and Assistant Administrators.

The medical service of the Veterans' Administration is thereby relegated to a subsidiary position not only in theory, according to the organizational set-up, but also in actual practice. The medical department can never function properly until its chief medical officer is elevated to the status of an Assistant Administrator, who reports directly to the Administrator and is given full authority and direct responsibility for the conduct of the medical and hospital services. (Record, pt. 5, pp. 1846–1847.)

Dr. Piersol, like many others, has recommended in his testimony the reorganization of the medical department of the Veterans' Administration and so stated:

It is believed that there should be established within the Veterans' Administration an organization comparable to the Bureau of Medicine and Surgery of the Navy, composed of the Assistant Administrator in charge of medical services and the heads of the various professional services, such as medicine, surgery, tuberculosis, neuropsychiatry, radiology, pathology, physical medicine, dentistry, research in postgraduate instruction, rehabilitation, and so forth.

Such a bureau, made up of the heads of the various divisions of the medical department, should have full authority to direct the medical policies of the Administration. Their ability to act in all professional matters should not be inhibited by the necessity of having to report to the Administrator through a lay intermediary. The heads of the various divisions should be men of outstanding ability in their respective fields and should be given compensation sufficient to attract physicians of the highest repute to such posts. (Record, pt. 5, p. 1847.)

Dr. Piersol also made recommendations in regard to a special medical advisory group for the Administrator of Veterans' Affairs and in his testimony stated, in part:

Some form of special medical advisory group to the Administrator should be made a permanent part of the organization. Such a group should be charged with the responsibility of critical study of methods and results. Attached to this group should be a full-time medical executive to act as a liaison officer between the advisory group, the Medical Director, the divisional heads, and the Administrator. (Record, pt. 5, p. 1847.)

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Dr. Piersol also strongly recommended regional consultants in medicine to be used in different parts of the United States and to cover the hospitals in their particular areas at frequent intervals:

A plan should be established for regional consultants in medicine, surgery, tuberculosis, neuropsychiatry, and so forth. These consultants should be outstanding specialists in their respective fields.

The plan to be followed should be patterned along that at present in effect in the Army, where in each service command there are consultants in the major fields of medicine and surgery. These consultants should visit each hospital in the region to which they are assigned at frequent intervals and should remain long enough to go over all the cases that come within their particular field. Such a group of consultants would be in a position to promptly recognize any professional or administrative faults or abuses that might develop from time to time. These should be reported promptly and directly to the chief medical officer and the Bureau of Divisional Heads so that they could be recognized and corrected by the Department at least as soon as they might become evident to the public.

The efficiency of central office medical inspection could be increased by more frequent visists to the various hospitals by the heads of the various medical and hospital services. These inspections should be directed particularly to the medical and professional care of the patients. Such central-office inspections should be regular, thorough, and complete, keeping primarily in mind the quality of the care rendered the patients and paying less attention to administrative details. (Record, pt. 5, p. 1848.)

Dr. Piersol made comments in regard to the separation of regional offices and hospitals in the following form:

Regional offices should be separated from and conducted independently of hospitals. It has been observed that the hospitals operate more effectively when they are divorced from a regional office. When the two are combined the chief medical officer of the hospital is responsible to the manager of the facility, who is almost always a layman and who may or may not be sympathetic with or interested in the medical problems of the institution.

"The chief medical officer of a veterans' hospital should be directly responsible to an Assistant Administrator in charge of medical services (now designated as Medical Director).

In each medical facility there should be trained administrative assistants to the chief medical officer appointed to take charge of the administrative details in the management of the hospital. Such administrative assistants could be competent laymen or medical men who prefer administrative work to clinical. Such a group of administrative assistants could relieve the medical personnel of a vast amount of clerical work which at present occupies so much of the time of physicians that their clinical activities suffer therefrom.

There should be appointed to each Veterans' Administration hospital competent consultants recognized as specialists in their respective fields. These consultants should be obtained preferably from local fields. These consultants should be obtained preferably from local medical schools or medical centers. They should be adequately compensated for their time and professional services rendered, should have regular days for visiting the hospitals and during these occasions they should see all the patients on their respective services, not merely limit their activities to the observation of selected cases. (Record, pt. 5, p. 1848.)

Recommendations were made in the following form as to training, both as to interns and graduate physicians of the senior staff:

Serious consideration should be given to the training of interns and residents in medicine, surgery, and the allied specialties in at least the larger Veterans' Administration hospitals.

Plans should be made for the graduate training of the senior staff members. Such graduate training should not be confined to veterans' facilities. Properly selected physicians should be sent to those medical institutions in this country where the best type of graduate training in any given field is available. The regulations of the medical department should be changed so that it will be possible for the medical officers to attend important national medical meetings without incurring personal financial loss. The medical officers of the Veterans' Administration should be given the opportunity to be certified by the various national specialty boards and they should be urged to become members of certain outstanding medical organizations. In this way the medical personnel

could be stimulated to acquire advanced medical education. By this method the Veterans' Administration hospitals can be better assured of well-trained, competent medical officers. (Record, pt. 5, pp. 1848, 1849.)

Dr. Piersol made recommendations to this committee as to the establishment and location of new hospitals in the following language:

When new veterans' facilities are constructed they should not be placed in remote locations but should be established in recognized medical centers so that the medical and scientific facilities of such centers can be readily made available for the better care of the patients.

The present tendency of new facilities to be located wherever the Army stands ready to transfer a hospital or camp, regardless of its location and accessibility to a medical center, is unsound and is not calculated to improve the medical care of veterans. (Record, pt. 5, p. 1849.)

Dr Piersol believes, that the present system of obtaining medical personnel through civil service should be definitely abolished.

One of the outstanding difficulties with which the medical department of the Veterans' Administration has been confronted and one which more than anything else has militated against the efficiency of medical care is the method by which all medical personnel are selected and the difficulty of obtaining a sufficient number of properly qualified persons.

The present system of obtaining medical and other professional personnel through the civil-service organization is definitely unsatisfactory and should be abandoned as soon as possible. Under the present system the Medical Director has virtually no opportunity to select. Until some method is adopted by which medical personnel can be properly chosen in accordance with their educational background and professional attainments, a first-class, well-trained, efficient group of physicians, nurses, and so forth, cannot be organized.

Under the present system of selection through civil service it is impossible to separate a medical officer who personally, temperamentally, or professionally is unsuited to the work without instituting complicated legal procedures.

Advancement in the service should be dependent upon periodic examinations and should not rest so much upon age, length of service, and the number of patients over which the medical officer is in charge as upon professional efficiency. It should be possible for the proper authorities to drop unsatisfactory or incompetent physicians without resorting to cumbersome and tedious methods.

The present salary schedule is too low to attract the right type of experienced physician to the service. (Record, pt. 5, p. 1849.)

Dr. Max Cutler

Dr. Max Cutler, of Chicago, Ill., an outstanding consultant in cancer, was also called by the committee. Dr. Cutler's statement, while brief, was impressive and he made some very clear-cut and far-reaching recommendations:

1. There should be established within the Veterans' Administration a department of medicine and surgery comparable to that of the Bureau of Medicine and Surgery of the Navy, the personnel of which should be appointed without regard to civil-service laws.

2. A greater use of the services of consultants should be made with adequate authority to carry out their responsibilities.

3. There should be established a plan of regional consultants in medicine, surgery; and the major specialists patterned on the Army plan.

These consultants should visit each hospital in the region several times a year.

4. The administrative and medical activities of the hospital should be separated as much as possible in order that the medical personnel may have the time and opportunity to concentrate on the purely medical and scientific aspects of the work.

5. The chief medical officer and the chiefs of the clinical services should be highly qualified for their respective positions.

6. A system of training of interns and residents should be organized comparable to that in university hospitals. There should also be established a system of graduate training in medicine and surgery and the specialties. Only through this means can the medical service of the Veterans' Administration be assured of well-trained and competent medical officers.

7. There should be an upward revision of the compensation schedules for medical officers.

8. The Veterans' Administration must accept its full responsibility toward medical science by continuing to encourage clinical research and thus contributing not only to the better care of the veteran but to medical science in general. (Record, pt. 5, p. 1874.)

Dr. Cutler upon being questioned by the committee, and before he closed, had the following to say:

I should say, I feel that the remarkable thing is not that somebody found a patient who was unhappy about his treatment, the remarkable thing is that so many patients have been treated so well.

There is no medical organization in the world that begins to compare in scope with the Medical Department of the Veterans' Administration, and it is simply amazing what good treatment so many patients have received over so long a period of time. That does not mean there is no room for improvement, and any doctor is constantly looking for methods of improvement, but certainly as I see it, the program, the medical care that the veterans have had, has been very good indeed. (Record, pt. 5, p. 1876.)

Dr. Malcolm T. MacEachern

Dr. Malcolm T. MacEachern, of Chicago, Ill., in appearing before the committee, brought a great deal of information in regard to hospitals. Dr. MacEachern is associate director and chairman, administration board of the American College of Surgeons, and as such, stated:

Another thing we (the American College of Surgeons) have recommended on several occasions, and I think it is something everybody is sympathetic to, is that these hospitals in the future should be near the medical centers where the men could go to the medical centers and keep up with the times, and also get into research as much as possible. * * * (Record, pt. 5, p. 1882.)

Now I want you to get this: You are not having this reorganization because of a whole lot of stories which we do not have much knowledge about. You are having it as a trend of the times. * * *

In other words, we recognize that we must get on a new level. In the last 4 years there has been difficulty in every hospital, their personnel has been pulled away, industry offers their personnel bigger salaries, the best doctors were taken away, the best nurses were pulled away. Some were kept home.

But there is not a hospital in this country that has not had its problems in the last 4 years. There is no question that many of their best doctors were taken into the war, and their best nurses. (Record, pt. 5, p. 1883.)

Now, in regard to the administration of veterans' hospitals in the future, our committee (medical advisory group) discussed the question of the central office having a medical director to be made an assistant director of the Veterans' Administration, and that he be charged with full responsibility to the Administrator for the medical services concerned with the care of veterans. * * *

It is also suggested that his designation be that of Director of Medical Services, United States Veterans' Administration. It is believed by the medical advisory group that there should be established within the Veterans' Administration an organization of the medical services of the Veterans' Administration a more definite and recognized status than at present.

Such a Bureau of Medicine and Surgery, or whatever the organization might be designated, would include the Director of Medical Services and the assistant directors in charge of the various professional services—that is, medicine, surgery, tuberculosis, neuropsychiatry, dentistry, radiology, pathology, research, and postgraduate instruction—and the liaison officer of the special medical advisory group of the Administrator. (Record, pt. 5, pp. 1883–1884.)

As far as the central-office inspection was concerned, the medical advisory group believes that the efficiency of the central-office inspection would be increased by more frequent visits of the heads of the various medical and hospital services to the extent of every 6 months or twice a year.

This inspection should involve particularly the medical or professional care of the patients. * * * Central-office inspection should be regular, thorough, and complete, keeping primarily in mind the quality of the care rendered the patient. * * *

We also recommended regional consultants. The medical advisory group recommends to the Administrator of Veterans' Affairs the establishing of a plan of regional consultants in medicine, surgery, tuberculosis, and neuropsychiatry who are specialists of recognized standing in their respective fields. The proposed plan would follow the pattern of the Army in each service command where there are consultants in the major fields of medicine and surgery. * * *

* * * Now, in addition to the regional consultant, there will be the local consultant—that is, men who can be called on in the community who are probably teachers in the university or who were fellows of the College of Physicians, College of Surgeons of Diplomates of the 15 boards.

These local consultants would be available for certain periods of time at the hospital, preferably a day a week or something like that, and they should be remunerated for it. * * *

We also discussed who shall administer the veterans' hospitals. We felt that there was a movement on—I understand there is a movement on—to separate the regional office from the hospital and this may be called a hospital again instead of a facility.

We think that would be a very good move, and that the chief medical officer of the hospital should be responsible to the Director of Medical Services of the Veterans' Administration. (Record, pt. 5, p. 1884.)

* * * the medical advisory group recommends that in each hospital one or more competent, trained, administrative assistants be appointed to look after all the administrative details in the management of the hospital working through well organized departments with competent heads for the carrying on of the various activities incident to the care of the patient. * * * In this connection, it is learned that there are some 18,000 men in the Medical Administrative Corps of the Army. This could well be a source of supply. * * * (Record, pt. 5, p. 1885.)

Our group also recommended, and we agree on the thing that the heads of the services in the medical service should be recognized specialists.

The medical advisory group recommends that so far as it is practicable and possible the heads of the various services in Veterans' Administration hospitals should be fellows of the American College of Physicians, fellows of the American College of Surgeons and/or diplomates of the various American specialty boards now numbering 15, or medical officers of equal standing. * * * (Record, pt. 5, pp. 1885–1886.)

We believe that these hospitals are able, in many instances, to have interns and residents. We believe that they should particularly train younger men in 3 to 4 years to grow up into the service to carry on the work. * * *

The medical advisory group believes that the medical officers of the Veterans' Administration hospitals have too much paper work under the present system and that the addition of medical secretaries and dictaphones would be most advantageous. There are now trained medical secretaries available. * * * (Record, pt. 5, p. 1886.)

The following is a survey of the Veterans' Administration hospitals by the American College of Surgeons, which was introduced in the record by Dr. MacEachern:

American College of Surgeons' Surveys of U. S. Veterans' Administration hospitals

[FA, fully approved; NA, not approved]

Location	Years surveyed	Bed capacity	Present rating
Alabama:			
Montgomery	1941	268	FA
Tuscaloosa	1935, 1942	621	FA
Tuskegee	1930, 1935, 1942	1,665	-------
Arizona:			
Tucson	1924, 1926, 1927, 1930, 1935, 1942	428	FA
Whipple	1925, 1927, 1930, 1932, 1935, 1942	527	FA
Arkansas:			
Fayetteville	1935, 1939, 1943	258	FA
North Little Rock	1924, 1935, 1940	1,625	FA
California:			
Livermore	1925, 1926, 1929, 1934, 1935, 1942	468	FA
Palo Alto	1924, 1926, 1929, 1934, 1935, 1942	1,417	FA

American College of Surgeons' Surveys of U. S. Veterans' Administration hospitals—Continued

Location	Years surveyed	Bed capacity	Present rating
California—Continued			
Los Angeles	1924, 1925, 1926, 1929, 1932, 1936, 1938	2,416	FA
San Fernando	1929, 1934, 1935, 1942	401	FA
San Francisco	1936	340	FA
Colorado: Fort Lyon	1925, 1927, 1930, 1932, 1936	1,026	FA
Connecticut: Newington	1933, 1939	427	FA
District of Columbia: Washington	1925, 1934, 1937, 1943	327	FA
Florida:			
Bay Pines	1934, 1937, 1941	619	FA
Lake City	1924, 1929, 1932, 1935, 1937, 1941	419	FA
Georgia:			
Atlanta	1924, 1934, 1937, 1941, 1942, 1944	415	FA
Augusta	1924, 1930, 1934, 1937, 1941	1,167	FA
Idaho: Boise	1924, 1925, 1929, 1931, 1932, 1936, 1943	203	FA
Illinois:			
Danville	1928, 1931, 1937, 1942	2,300	FA
Downey	1926, 1931, 1937	1,600	FA
Dwight	1936	196	FA
Hines	1924, 1931, 1944	2,029	FA
Marion	1943	214	FA
Indiana:			
Indianapolis	1933, 1937, 1944	345	FA
Marion	1927–1929, 1931, 1937	1,509	FA
Iowa:			
Des Moines	1934, 1939	545	FA
Knoxville	1925, 1928, 1930, 1934, 1939	1,605	FA
Kansas:			
Wadsworth	1924, 1925, 1934, 1940, 1943	742	FA
Wichita	1934, 1936, 1939, 1943	248	FA
Kentucky:			
Lexington	1932, 1935, 1941	663	FA
Outwood	1924, 1939, 1932, 1935, 1941	375	FA
Louisiana: Alexandria	1924, 1926, 1928, 1932, 1934, 1940	739	FA
Maine: Togus	1925, 1926, 1930, 1933	1,234	FA
Maryland: Perry Point	1924, 1937, 1943	1,633	FA
Massachusetts:			
Bedford	1935, 1939	1,749	FA
Northampton	1924, 1930, 1935, 1939	1,002	FA
Rutland Heights	1924, 1930, 1935, 1939	469	FA
Michigan:			
Dearborn	1942	463	FA
Fort Custer	1924, 1935, 1940	1,723	FA
Minnesota:			
Minneapolis	1931, 1934	786	FA
St. Cloud	1925, 1936, 1941	1,197	FA
Mississippi:			
Biloxi	1934, 1941	208	FA
Gulfport	1930, 1934, 1941	785	FA
Missouri:			
Excelsior Springs	1924, 1931, 1934, 1940	267	FA
Jefferson Barracks	1924, 1931, 1934, 1940, 1944	263	FA
Montana: Fort Harrison	1925, 1930, 1943	184	FA
Nebraska: Lincoln	1931, 1934, 1936, 1939, 1944	379	FA
Nevada: Reno	1936, 1942	26	FA
New Jersey: Lyons	1934, 1938	1,925	FA
New Mexico:			
Albuquerque	1932, 1935, 1942	313	FA
Fort Bayard	1925, 1927, 1930, 1935, 1942	305	FA
New York:			
Batavia	1936, 1944	295	FA
Bath	1931, 1937, 1944	428	FA
Canandaigua	1933, 1937, 1944	1,275	FA
Castle Point	1924, 1931, 1936, 1944	625	FA
New York City	1924, 1938, 1945	2,090	FA
Northport, Long Island	1940, 1945	2,685	FA
Saratoga Springs	1944	47	NA
Sunmount	1924, 1931, 1933, 1936, 1944	589	FA
North Carolina: Oteen	1924, 1930, 1934, 1938, 1944	1,269	FA
North Dakota: Fargo	1930, 1933, 1936, 1941	159	FA
Ohio:			
Brecksville	1941	285	FA
Chillicothe	1924, 1927, 1935, 1941	1,860	FA
Dayton	1932, 1935, 1937, 1943, 1944	1,077	FA
Oklahoma: Muskogee	1924, 1931, 1934, 1936, 1939, 1943	428	FA
Oregon:			
Portland	1932, 1936, 1938, 1943, 1945	623	FA
Roseburg	1936, 1943	566	FA
Pennsylvania:			
Coatesville	1936, 1941, 1945	1,728	FA
Pittsburgh (Aspinwall)	1933, 1936, 1944	1,134	FA

American College of Surgeons' Surveys of U. S. Veterans' Administration hospitals—Continued

Location	Years surveyed	Bed capacity	Present rating
South Carolina: Columbia	1934, 1937, 1942, 1944	606	FA
South Dakota: Hot Springs	1924, 1925, 1927, 1931, 1936, 1941	276	FA
Tennessee:			
Memphis	1924, 1930, 1932, 1935, 1941, 1942, 1944	565	FA
Mountain Home	1924, 1929, 1932, 1934, 1937, 1941	553	FA
Murfreesboro	1941	1,007	FA
Texas:			
Dallas	1941	352	FA
Legion	1925, 1930, 1935, 1940	409	FA
Waco	1935, 1938, 1940	1,394	FA
Utah: Salt Lake City	1936, 1943	204	FA
Vermont: White River Junction	1939	188	FA
Virginia: Kecoughtan	1924, 1925, 1930, 1932, 1938, 1943, 1944	528	FA
Washington:			
American Lake	1924, 1926, 1930, 1936, 1943	789	FA
Walla Walla	1929, 1936, 1943	421	FA
West Virginia: Huntington	1937	321	FA
Wisconsin:			
Mendota	1938	282	FA
Wood	1925, 1927, 1932, 1935, 1938, 1942, 1944	1,403	FA
Wyoming:			
Cheyenne	1936, 1939, 1943	212	FA
Sheridan	1925, 1927, 1930, 1936, 1943	594	FA

Total hospitals	89
Total beds	68,925
Total surveys	324

(Record, pt. 5, pp. 1897–1898.)

In the interest of conserving space and for brevity, without quoting the same in this summary we wish to call attention to the American College of Surgeons—Manual of Hospital Standardization, guide-post and chart by which the hospitals throughout the United States are inspected and evaluated by the American College of Surgeons. This Manual of Hospital Standardization will be found in the record, part 5, pages 1899 to 2026, inclusive.

Surveys have been made by the staff of the American College of Surgeons in 20 hospitals for teaching purposes. The 20 hospitals will be found listed in part 5, page 2026, of the record and following the names of the 20 hospitals will be the report submitted by the American College of Surgeons on each of these hospitals. (Record, pt. 5, pp. 2026 to 2085, inclusive.)

Dr. Roy D. Adams

Dr. Roy D. Adams, of Washington, D. C., in his testimony stated, in part:

In the first place the establishment of a medical service with a recognized standard and with a corps selected in such a fashion as to obtain the best possible medical talent, particularly so far as young men are concerned, with a power to act in medical matters so that those young men and the older ones for that matter have not only the opportunity but the necessity of keeping up with modern medicine through courses in the Veterans' Administration hospitals which are properly located and staffed to give such courses, and especially the privilege of attending courses in universities where courses are presenting things which are needed particularly by the individual in his chosen work, and that such organization must have the dignity of the Public Health Service, the Army or the Navy Medical Corps, that so far as the functioning of those members is concerned, regardless of what kind of an organization is ultimately decided on, the emphasis should be placed on the physician and not the physician's rank. * * *

That is, that the medical corps or medical service of the Veterans' Administration should be made up of doctors, not of colonels or captains or lieutenant colonels, or what you will, that such rank might well be possessed by those members,

but in the last analysis the functions of the members of the Veterans' Administration medical service should be first as doctors, and should be so thought of by the patients in the hospitals. * * * (Record, pt. 5, pp. 2088–2089.)

In that connection I think there should be where medicine is practiced no Veterans' Administration facilities, but Veterans' Administration hospitals. (Record, pt. 5, p. 2090.)

Dr. Adams, upon being questioned as to why the medical advisory group had not previously recommended reorganization of the Veterans' Administration, produced in the record the following resolution which was passed at the eighth conference of the medical council in April 1928:

Whereas at the first meeting of the Medical Council of the United States Veterans' Bureau, after due deliberation, the council went on record that "the only way in which the highest grade of medical service can be offered to the ex-servicemen who are referred to the Bureau for care, is by having an independent medical corps, similar to the organization of the United States Public Health Service, or the Medical Corps of the United States Army or Navy"; and

Whereas the council, at its meeting, November 1924, submitted the text for a bill to create a permanent medical service in the United States Veterans' Bureau, and

Whereas at every successive meeting of the Medical Council the council has gone on record as favoring the creation of such a permanent medical service, and

Whereas at the present time the committee in charge of veterans' legislation of Congress has before it for consideration, a bill, H. R. 12627, which provides for the establishment of a commissioned medical service in the United States Veterans' Bureau, and is now holding hearings on that bill: Be it

Resolved by the Medical Council of the United States Veterans' Bureau, in stated meeting assembled, That it is the unanimous opinion of its members that in order to assure proper care of the wards of the Government, which, under the laws of Congress the Veterans' Bureau is obligated to provide, it is necessary to attract and to retain in that service physicians and surgeons who are thoroughly competent to render the highest type of medical service; and that, in order to accomplish this, a career of dignity and stability must be provided similar to that of the Medical Corps of the Army, the Navy, and the Public Health Service; and that the only way in which this can be accomplished is by the creation of a medical corps in the Veterans' Bureau such as is provided in the bill now under consideration; and be it further

Resolved, That the Director of the Veterans' Bureau be requested to transmit a copy of this resoution to the respective chairmen of the Committees on Veterans' Legislation of the Senate and House of Representatives, with the least practicable delay. (Record, pt. 5, pp. 2090–2091.)

In speaking of the inspection of Veterans' Administration hospitals Dr. Adams stated as follows:

May I say that the inspection of hospitals by the American College of Surgeons is the most extensive and exhaustive and extended survey which is made of hospitals in this country at the present time. (Record, pt. 5, p. 2092).

In speaking of the mental aptitude and professional attainment of the average doctor connected with the Veterans' Administration hospitals, as compared with doctors in private hospitals, Dr. Adams stated as follows:

I would say that the average is as good, that there are a number of men serving in veterans' hospitals whom I would not like to have if I had charge of a hospital, but that obtains in most any hospital. The general standard, I think, is as good as that met in the general run of hospitals, not as good as that in teaching institutions nor university hospitals, but for the general run of hospitals. I think the medical personnel is as good. However, there is serious difficulty in the selection of men for positions in the Veterans' Administration. Under the existing system a considerable proportion of undesirables are bound to be appointed, and are separated with considerable difficulty. I think that is such a criticism as can be leveled by any fair-minded body investigating the hospitals. I think it would indicate the desirability of appointment of men by examination other than the

assembled examination by the Civil Service Commission and especially by personal contact with the individual by a board who examines that individual, by a procedure similar to the one employed by the Public Health Service * * *. (Record, pt. 5, p. 2093.)

I think there could have been at times considerably more enthusiastic support of recommendations made by the advisory council with regard to postgraduate courses, teaching, and research work. (Record, pt. 5, p. 2094.)

Dr. William F. Lorenz

Dr. William F. Lorenz, Madison, Wis., appeared before the committee. Dr. Lorenz is a professor of psychiatry, University of Wisconsin Medical School, and is chairman of the Wisconsin State Board of Mental Hygiene. Dr. Lorenz, in his testimony, which was confined for the most part to mental patients, stated in part as follows:

There is a tremendous advantage in having the veteran hospitalized with those of his own group, where they have had common experiences. After all, a veteran, even when he is quite mentally incompetent, is still quite conscious of the fact that he has been a soldier. So that because of their common experience and the carrying over of a lot of experiences of a soldier into his veteran state, it is a decided advantage in treating him and in stabilizing him and in seeking to cure him, rather than mixing him with those who came from a different background. (Record, pt. 5, p. 2104.)

I made some inspections—not mere visits—of hospitals or facilities—I don't like that term—operated by the Veterans' Administration at Galesburg, Ill., Chillicothe, Ohio, Perryville, Md., Coatesville, Pa., Leavenworth, Kans., St. Cloud, Minn., the Hines Hospital, the Mendota facility in Wisconsin, and the facility at Wood, Wis.

I wish to say that in making those inspections I follow a certain method that I choose to call an audit; not a financial audit, by any means, but a human audit. In other words, I go to those places, of course authorized by the Administrator, but unannounced. I then request the manager to give me a list of the cases that were admitted during the previous 2 months. Then I will take 20 or 30 of those cases as they run—the "mine run," no exceptions—and arrange them for a personal private interview with each such patient, alone in a room. I ask for the medical record such as they have made up to that time. Then I have this interview. I size up the patient, study the record, and am able to judge to a degree, at least, how much of this person's mental disorder and illness appears in the record. Then I note particularly what program of treatment, and so forth, has been proposed; and if perchance I have some idea as to trying out some other form of therapy, at the second day or the third day I will discuss some of these cases with the clinical director or the junior members of the staff.

I call that "auditing" the patient. I find that they do make very careful audits of all property and money, and so forth, down to a penny, but I think the auditing of the patient is probably equally important. * * *

It has been based on the direct personal contact with patients, and not by mere hearsay or casual observation. (Record, pt. 5, p. 2105.)

On the basis of my experience—and I have a background of State hospital service and am quite familiar with State hospitals—I can state very honestly that right today I believe the veteran who is suffering from a mental ailment is receiving better care and better treatment than his sister or his brother or his mother or his father who might be unfortunate enough to be suffering a mental ailment. (Record pt. 5, pp. 2105–2106.)

Dr. Lorenz, in being questioned about the mistreatment of patients, stated as follows:

My general answer is this—and I say this advisedly: It is my firm belief that there is far less abuse, far less mistreatment in a physical way or any other way, of a veteran in a veterans' hospital than can obtain and does obtain to civilians in civilian hospitals. * * *

I think it is because it is a policy. I think there is an attitude of protection that is thrown around a veteran. I think that that stems right from the central office all the way down. The rules and regulations and the practices required by central office regulations are of an extraordinary character. In fact, I think they go beyond what is necessary to protect the patient from abuse and mistreatment. The managers, without exception, are very much concerned about that. (Record, pt. 5, p. 2108.)

In speaking of inspections and the coverage of mental hospitals by undercover men for the protection of the patients in the hospital, Dr. Lorenz stated as follows:

I agree with you insofar as the desirability of having some force outside, or not directly a part of, the Administration make such contact as to be able to detect the hidden cases of using a towel around the neck, and so forth, which is not an uncommon practice.

I would like, for that reason, to cite one of the reasons for my personal interview with these patients. That is always a part of the inquiry. You have got to be well-informed as to a mental state to separate facts from fancy, however, but you can by that audit of the individuals detect instances of abuse or mistreatment which escapes the attention of the management. I think a strong inspection service, a powerful inspection service, that is wholly removed from any possibility of pressure or influence of any kind, is a very, very important thing in the operation of a large number of institutions dealing with mental disorders.

New York State adopted such a policy years ago and, as far as I know, it still continues, so that the patient away back in these big wards that ordinarily might be forgotten is audited by some very responsible authority that has authority greater than that of the management. * * *

Certainly there should be leadership; I mean, a very competent clinical director. The manager should be a good neuropsychiatrist, and the senior group should be experienced and highly qualified men. You can infiltrate the younger element in there who are getting practical experience and, by staff meetings or other means, are being developed. They need not be 100-percent neuropsychiatrists right down to the lowest grade of medical member of the staff. At all mental hospitals you have got to have physicians who represent other fields of medicine. (Record, pt. 5, p. 2109.)

In testifying in regard to shackles or restraints put on patients in hospitals, Dr. Lorenz had the following to say:

There were six veterans' hospitals for mental diseases that I surveyed and spent sufficient time in and went around alone and did not accept merely information, but sought by all means that I possessed, and I found four cases in which there was physical restraint used, and in each one of those cases I would have ordered it myself. We operate a psychopathic department at the university hospital, and we have to use physical restraints every once in awhile. It is humane; it is necessary for a patient's welfare. (Record, pt. 5, p. 2110.)

The five specialists who have been called before this committee, either in their statement or in answer to questions by counsel or the committee, have testified that in their opinion the Veterans' Administration should have a department of medicine and surgery within the Administration and that department should be headed by a physician who is an Assistant Administrator and not a layman. Dr. Piersol so testified. (Record, pt. 5, pp. 1847, 1861.) Dr. Cutler so testified. (Record, pt. 5, p. 1879.) Dr. MacEachern so testified. (Record, pt. 5, pp. 1896, 1897.) Dr. Adams so testified. (Record, pt. 5, p. 2090.) Dr. Lorenz so testified. (Record, pt. 5, p. 2109.)

Dr. Charles P. Murphy

Dr. Charles P. Murphy (lieutenant colonel, Medical Corps, Army of the United States) was called before the committee. Dr. Murphy at that time was manager of the Veterans' Administration hospital at Livermore, Calif. The hospital at Livermore is designated and operated for the treatment of tuberculosis. The reports received from the American Legion, Veterans of Foreign Wars of the United States, and the Disabled American Veterans revealed that the hospital at Livermore was not on a par with other veterans' hospitals throughout the United States. The complaints varied somewhat, but all agreed that the kitchen and dining-room equipment was not sufficient for the size of the hospital at this time. Some of the reports indicated that

there was a great deal of friction between the manager, clinical director, and other members of the staff. The condition, as a whole, as revealed by the reports of the veterans' organizations, was certainly anything but encouraging. No complaints had reached this committee from other sources than above stated; however, the complaints which the veterans' organizations registered were such that the committee felt that the manager of the hospital should be called before the committee in order to answer the serious charges made.

Dr. Murphy's testimony before the committee was not convincing. His statements, in answer to the questions propounded, left a grave doubt as to the proper management and supervision of the hospital at Livermore. It was reavealed, however, that Dr. Murphy had been on duty as manager at the Livermore Hospital approximately 2 years (record, pt. 5, p. 2134) at the time he testified before the committee and that he had made an effort to rectify some of the conditions that apparently existed and had existed at the hospital for a number of years. This evidence was brought out by correspondence introduced by Dr. Murphy under date of March 14, 1945, in which he had brought to the attention of the central office of the Veterans' Administration certain things, namely, the revision of the main kitchen and dining room at the Livermore Hospital. The letter stated in part:

> With reference to the possible revision of the main kitchen and dining room at this station, which has been under consideration since December 1943, certain definite steps should be taken immediately to draw up plans and get construction under way, not only from the standpoint of increased bed capacity but from the problem now involved of keeping some of the old equipment in running condition until new can be purchased. Until plans are drawn showing size and location of rooms, it is impossible to purchase equipment of the right size to be adaptable to the space and the needs of the station. * * * (Record, pt. 5, p. 2147.)

In this letter Dr. Murphy further stated the deplorable condition of the kitchen equipment at the hospital. At the time of the hearing no action had been taken to relieve the situation at the Livermore Hospital. It is believed that they could not, at most, charge all of the trouble to Dr. Murphy for the condition under which he was required to operate at the time his testimony was heard, and further that the central office of the Veterans' Administration could, and should, have taken necessary steps more promptly to at least assist Dr. Murphy in his problems at the station to which he was assigned. It was further revealed by the testimony of Dr. Murphy that a great deal of surgical equipment was acquired by the hospital as late as the summer of 1945. (Record, pt. 5, p. 2131.) Dr. Murphy's testimony would indicate that his clinical director prior to that had not requested additional equipment and that the oprating room had for a number of months been in such condition that the hospital was at this time using a temporary operating room on account of construction and remodeling. (Record, pt. 5, p. 2132.)

The reports reaching this committee through the veterans' organizations have revealed that preservation of food was not up to standard, and it has been brought out by this same testimony that the dishes and utensils in which the food was served in some cases were not even clean. In questioning Dr. Murphy about this condition, he stated:

> Well, I would not say that they have all been clean. They have brought me dishes that were dirty at times, off trays, and they have brought me glasses that

were dirty. Just before I left there, it was not clean. I went right over to the dietitian with it, and we take up those things right away and work on it, but it is a constant job. You cannot just say, "Keep those dishes clean," and forget it. It is not done that way. You have to stay right on the job and keep right after them. (Record, pt. 5, p. 2139.)

The over-all picture revealed by the testimony introduced pertaining to the Livermore Hospital presents a problem for the Administrator of Veterans' Affairs, and particularly his Department of Medicine and Surgery. Appropriate action should be taken without delay to supply necessary equipment to bring the physical aspects of the Livermore Hospital up to the standard of other Veterans' Administration hospitals throughout the United States.

Dr. Charles M. Griffith

Dr. Charles M. Griffith, Medical Director of the Veterans' Administration, was called before the committee. Dr. Griffith's statements were in defense of the position in which the Veterans' Administration found itself after the opening of hostilities in World War II. Dr. Griffith stated the situation in the Veterans' Administration in the selection of medical personnel.

Up until the summer of 1940 or early fall of 1940, we had a hospital service that was second to none—not second to any in the country; but when they started to mobilizing the National Guard and calling in the Reserve, a large part of our personnel were either in the Reserve or in the National Guard; it was mandatory that the National Guard officers and enlisted men go into the service. When they called the officers in—I am speaking of medical officers now—at that time also there was called into service many of our best cooks, technical employees, such as plumbers and technicians of all kinds. All of that group of personnel was in the classified civil service. They were able to make replacements the first time; but, mind you, gentlemen, those employees that I speak of, who were called into service, were trained and had 15, 20, and 25 years' experience, and they were thoroughly trained on their respective jobs.

* * * * * * *

Then conferences were held with the Commission (Civil Service Commission) about the problem. Frankly, I was worried about it, because I did not think that the Commission would be able to give us the proper people we needed. They assured the Administrator on numerous occasions, the Civil Service did, that they could meet the situation. It was some of the higher officials of the Civil Service Commission that assured the Administrator that they would meet the issue. They will tell you now that they can. And then, as the war progressed, we had large numbers of personnel that were of military age; they were not in uniform. Hundreds of our younger and best doctors and nurses were told thousands of times by their friends, by their patients, and by others, "You are a slacker and you ought to get into the service." Now, you can imagine how that individual would feel about it.

Consequently, many of them resigned, when we were trying to hold them. They were assured that they would be protected if there was any way to protect them, but that did not meet the issue.

Later others went; and each time the Commission, in the case of centralized employees, would replace, or the manager in the field would replace in those decentralized positions the previous incumbent with an individual whose quality was poorer than his predecessor. (Record, pt. 5, p. 2156.)

Now, we appealed to the War Manpower Commission and to various other agencies. We got no help from them. The Administrator went, on numerous occasions, to the War Manpower Commission, to the Selective Service, and to others, trying to retain some of the personnel; but with public sentiment demanding that every able-bodied man and woman go into the military service, they left, and if I was their age, and in their position, I would have done likewise. In fact, I did in '17.

Now, again, a factor that enters into the question of getting personnel. Since war was declared, all appointments are for the duration, i. e., temporary appointment; and any good, available, and competent employee is not inclined to take a

temporary position when he feels that as soon as this war is over all of these jobs are going to ex-service men and women. Now, almost everybody has that feeling.

There has been considerable criticism about the selection of personnel.

Frankly, I think the operating agencies, meaning the directors of service, should have some say in the selection of their personnel, all types of them.

It is true that technically you can take your choice of one out of three. Say I need a doctor at station A. I want a general medical and surgical man. The Civil Service will give me three names. Personally, I do not know them. You have to decide on the history given. If you do not take the top man, then you have got to write a thesis explaining why you did not, and I mean "thesis." * * *

And even after you have rejected them, and if you ask for one next week, they will send you the same man back, and then you have got to do it all over again.

In reading various reports, there is a lot said about "too much central office control." If you did not have central office control over these field stations, you would be running 96 different ways.

It has been said they do not have selection of doctors. Since the war has progressed, we have permitted the field to pick up all types of medical personnel. Eight doctors were certified to me for placement to go on. They all had a penitentiary record and they were either about vice or trading or dealing in narcotics or things of that character. * * *

* * * we gave the field authority, the local managers authority, to employ men temporarily.

Now, the field managers had no way on earth of knowing these men's past records. We and Washington do. We can check through the FBI and through various services and get the record. That is how we picked their records up.

Now, if he is an undesirable doctor, and he has been in trouble in California, he is applying in Chicago or New York to the local manager, and he will give you a beautiful story. * * *

The manager picked them up and they were put on duty, and then the Civil Service Commission would classify them. (Record, pt. 5, pp. 2156, 2157, 2158.)

In speaking of nurses and the difficulties which were encountered by the Veterans' Administration, Dr. Griffith had the following to say:

* * * quite a lot was said about nurses and the recruitment of nurses. Under civil service a nurse was considered subprofessional and did not have a professional status with the Civil Service Commission. However, all other agencies, military, and civilian institutions, gave a nurse a professional status. That stopped hundreds upon hundreds of nurses from coming with us. The Administrator worked on numerous occasions and tried to accomplish something with the classification people and the civil-service people. * * *

* * * The Civil Service Commission said that there were certain acts of Congress, and I do not know them, which prevented them from doing it. Now the Administrator argued the thing for a year and then said he would give them a professional status and did as of July 1 of this year. * * *

Now during the year 1942 we recruited 1,419 nurses. Those nurses would come on duty. They were promptly told by the personnel on duty and by the patients that they were only appointed for the duration. They would be told: "You are an able-bodied young woman and you should go into the military service." Most of them promptly did.

In 1943 we recruited 1,087 nurses and assigned them to duty. Now each month, say, we recruited 500 nurses; the resignations would just exceed the appointments from 5 to 10 percent at least, letting the load go on down each month. (Record, pt. 5, pp. 2164–2165.)

* * * we have permitted the field, and do still permit them, to recruit nurses. They send their record in, the school of graduation, and so forth, and it has to be a grade A school, recognized by the State. But after all, nurses resign to go to service and into other jobs, just as the doctors. We have several hundred nurses in military service today. (Record, pt. 5, p. 2159.)

Previous to 1940 we had trained team units of nurses, technicians, medical, and various staff personnel. I will try to illustrate this way: Take 20 trained doctors who work on a team. They all had different personalities but they have learned to adjust and to give and take, and a trained team of 20 can do twice as much as an untrained team of 50. (Record, pt. 5, p. 2169.)

Dr. Griffith's own testimony is some indictment of the way in which the present medical department of the Veterans' Administration has been operated. In speaking of nurses and the central-office information in regard to nurses in the field, Dr. Griffith had this to say:

> July 1, 1930, they combined the national homes with the veterans' facilities and the nurses in the national homes were not under civil service; and after we consolidated, they blanketed all of those nurses in, and through an oversight on everybody's part—at least that of the Veterans' Administration—we thought they were all graduate nurses. No one ever thought otherwise. Apparently the Civil Service did not catch it.
>
> Now I have known for 2 years that there was something wrong at Dayton, and I tried every way in the world to find out and I had my troubles. I sent nurses down there and I knew they would not stay. Then I finally took it up with the State director of nurses in Ohio and got her to tell me why we could not have cadet nurses there, and she told me that we had 14 or 16 nonregistered nurses who could not meet the requirements of the State board of examiners in their own States, and that they had graduated from inferior schools in the State of Ohio and maybe some other States; I do not know. (Record, pt. 5, p. 2217.)

Dr. Griffith placed in the record, which is reproduced in this report, the Veterans' Administration statement showing the status of full-time physicians, nurses, and attendants from June 30, 1940, to April 30, 1945:

Veterans' Administration statement showing the status of full-time physicians, nurses, and attendants for selected dates

Dates	Physicians (full time)				Nurses			Attendants (excl. memb. pas) [1]			
	Authorized	Filled by civilians	Filled by commissioned officers	Actual vacancies	Authorized	Filled	Vacancies	Authorized	Filled by civilians	Filled by enlisted men	Actual vacancies
June 30, 1940	1,711	1,657			4,257	4,116	141	16,556	15,895		661
Total hired or assigned during year		305				782			7,863		
Total separated from service during year		207				513			7,076		
June 30, 1941	1,790	1,755		35	4,536	4,385	151	17,328	16,682		646
Total hired or assigned during year		357				875			10,667		
Total separated from service during year		396				1,037			10,969		
June 30, 1942	1,815	1,716		99	4,670	4,223	447	17,883	16,380		1,503
Total hired or assigned during year		130				1,228			12,189		
Total separated from service during year		197				1,595			13,545		
June 30, 1943	1,747	1,649		98	4,455	3,856	599	17,050	15,024		2,026
Total hired or assigned during year		216				1,349			11,047		
Total separated from service during year		1,046				1,294			11,224		
June 30, 1944	2,234	819	1,098	317	4,857	3,911	946	18,350	14,847	2,025	1,478
Total hired or assigned during year		102				1,701			[2]		
Total separated from service during year		302				1,159			[2]		
Apr. 30, 1945	2,528	619	1,690	219	5,450	4,453	997	20,606	14,828	4,416	1,362

[1] Attendants include hospital attendants, barbers, mess attendants, waiters, cooks, bakers, maids, housekeepers, matrons, seamstresses, and laundry helpers.
[2] Not available.

NOTE.—(*a*) Figures indicated for additions and separations to the rolls are approximate. (*b*) The filled positions of physicians include the following assigned to rating board: June 30, 1940, 145 civilians; June 30, 1941, 137 civilians; June 30, 1942, 139 civilians; June 30, 1943, 131 civilians; June 30, 1944, 236 civilians, 126 commissioned officers; June 30, 1945, 196 civilians, 171 commissioned officers.

(Record, pt. 5, p. 2160.)

Dr. Griffith is in favor of a Bureau of Medicine and Surgery within the Veterans' Administration and so testified as follows:

* * * out of 2,562 men on duty, Veterans' Administration physicians, commissioned and retired, in the hospital service, 1,102 are from the Army and 2 from the Navy, or a total of 1,104. Former Veterans' Administration employees returned to duty in the medical and hospital service by the armed forces were 98.

Commissioned officers on detail in the medical and hospital service were 554 from the Army and 16 from the Navy, or a total of 570.

The total commissioned officers on duty in the medical and hospital service are 1,754 from the Army and 18 from the Navy, or 1,772 altogether. The total civilian medical officers in the medical and hospital service are 423, so that there is a total Army and Navy and civilian physicians in the hospital service of 2,195. (Record, pt. 5, p. 2197.) [Note.—367 physicians on duty with Adjudication Service.]

* * * doctors on duty, representing all classifications, and about 75 percent, or 74 percent and a fraction, are in uniform. The others are civilians who are strictly under civil service. Now there has been a whole lot of talk about this compensatory time off. The Army has a regulation that you have got to do certain things and this has got to be verified—under a Ramspeck bill a doctor either had to have overtime if he worked over 8 hours or compensatory time. Now when you take in the holidays and take in all this compensatory time stuff that he has to have off duty, I am not in sympathy with any of that. * * *

* * * you cannot legislate laws for a doctor that will apply to a plumber, a technician, a carpenter, or an engineer. (Record, pt. 5, p. 2169.)

I am in favor of the Bureau of Medicine and Surgery, call it a corps or whatever you want to call it. I am in favor and advocating, and want to be able for the Administrator and the Medical Director to be able to select and set up the necessary machinery to select all of our personnel. (Record, pt. 5, p. 2210.)

Mr. Louis H. Tripp

Mr. Louis H. Tripp, Director of Construction Service of the Veterans' Administration, was called before the committee. Mr. Tripp testified as follows in regard to construction work in progress:

* * * However, since Pearl Harbor we have completed about $13,700,000 worth of construction work, and we have now under construction $37,000,000 worth, which is twice as much as we had ever handled prior to the present war. Much of it has been handled without any material increase in force. Our force now has been increased and our production is much higher. (Record, pt. 5, p. 2240.)

Mr. Tripp, in commenting upon the testimony of Dr. Murphy, manager of the Veterans' Administration hospital at Livermore, Calif., had the following to say:

A day or so ago there was criticism of some of the conditions that existed at Livermore, and I would like to comment briefly on some of those matters that relate to confusion and delay in delivery of kitchen equipment, improper equipment, and the reorganization of the kitchen building.

I think the first item that was mentioned was that of a sterilizer which is needed for the new operating room which is now being overhauled. We, frankly, ran into difficulties, and the responsibility for that is between my own office and that of Mr. Kidd, and, I think, very largely the contractor who took the order.

On July 7, 1944, I approved a requisition for that sterilizer. It was sent to the Supply Service and bids were received, and on August 28 I returned the file recommending acceptance. I think that that was accepted in due course, but it was not until January 6, 1945, that the contractor advised the Supply Service that he could not furnish that particular type of sterilizer. I do not know the circumstances; but that was a delay that apparently was the fault of the man who took the order for that piece of equipment. (Record, pt. 5, p. 2240.)

Mr. Tripp, in commenting on the kitchen equipment at Livermore hospital, in contrast to the statement of Dr. Murphy, stated:

* * * We have had no request for a dishwasher. As Colonel Murphy said, it would be desirable in the case of a piece of equipment like a dishwasher to have it fitted to the space that it is going to occupy permanently; and since that kitchen

is to be rearranged, it would be desirable to have the new equipment fit the new kitchen. But I want to make it entirely clear that under no circumstances did we permit and would not knowingly permit an item of equipment to remain in the service if it was not capable of washing and sterilizing the dishes as it is supposed to do. To the best of my knowledge, we had never been informed of that situation until this investigation.

Regarding the addition to the kitchen and dining hall building, that matter has been under discussion for a year and a half. There has been a definite difference of opinion as to whether or not a major addition would be required. I would like to point out, however, that this hospital was completed and opened on the 11th of April 1925, with a capacity of 306 beds. The kitchen was enlarged once in 1926, and since then has furnished the service required so far as our records indicate. The subsistence supervisor is at Livermore at present, my representative will be there, and plans and arrangements will be worked out which will provide for satisfactory operation.

From the figures that were quoted here the other day the patient load there at present is no greater than the place was designed for originally, or very little greater than the capacity of the hospital now, 462 beds as compared with an initial capacity of 306 beds. (Record, pt. 5, p. 2241.)

The conflicting testimony of these two witnesses makes it very hard for the committee to put their finger on any particular department that might be responsible for the conditions which were revealed at Livermore. It goes without saying that certain irregularities may creep into an organization as large as that of the Veterans' Administration, yet there is no reason for not placing definite responsibility for the condition with which we are confronted.

It would appear from the testimony of Mr. Tripp that the building program has progressed rather steadily but still not fast enough to take care of the veterans who would come to the Veterans' Administration hospitals for treatment since discharge from World War II. Mr. Tripp placed in the record parts of a memorandum which he had discussed at various times with Colonel Ijams and the Administrator. This memorandum is in regard to planned construction and is as follows:

At present and the next 6 to 12 months will probably represent the most unfavorable time to undertake large additional construction, both from the standpoint of the Veterans' Administration and from that of the general war effort. Any decision to undertake construction of large additions to our facilities in a short time would probably involve the adoption of frame construction, fee basis contracts, and the extraordinarily high costs which prevail at this time. A decision to build at this time but without attempting very rapid construction would involve a choice between our present standards of design modified as may be necessary and a simplified design in fireproof construction. High costs would be involved in either case, although the work could probably be done by lump-sum contract under competitive bids, and the time for completion would be uncertain.

Any construction work undertaken at this time would be in direct competition with the war effort. On the other hand, work undertaken after the peak of war construction has passed will help to stabilize the industry.

In conclusion I would like to again emphasize the need for an early start on plans. There is no question in my mind that we would be better off financially if we planned $20,000,000 worth of construction and then only built $5,000,000 worth of it than if we wait until the emergency is on us and then have to plan $5,000,000 worth of construction under rush conditions. Taking cognizance of the trend of the present situation and taking prudent steps toward meeting it at the proper time would also furnish an answer to various criticisms, suggestions, and inquiries which we are receiving from time to time. (Record, pt. 5, pp. 2250–2251.)

Mr. Tripp, in his testimony, placed before the committee certain figures showing the progress of the building program and the number of beds furnished by that program:

On November 30, 1941, the Veterans' Administration was operating 91 facilities. The number of beds available and the number of patients of each type in veterans' hospitals and members present in domiciliary barracks were as follows:

Type	Beds available	Patients
General medical and surgical	20,750	16,813
Tuberculosis	5,193	4,653
Neuropsychiatric	35,902	33,914
Total, hospital	61,845	55,380
Domiciliary	18,725	15,809

(Record, pt. 5, p. 2255.)

At the present time (March 31, 1945) 95 facilities are in operation and figures as to capacity and occupancy are as follows:

Type	Beds available		Patients
	Stated capacity	Over capacity	
General medical and surgical	[1] 19,418	3,468	16,111
Tuberculosis	7,889	9	6,348
Neuropsychiatric	40,101	6,338	42,651
Total, hospital	67,408	9,815	69,569
Domiciliary	[2] 12,910	437	9,448

[1] Decrease in general medical and surgical beds available is a result of a greater utilization of beds in tuberculosis hospitals for tuberculous patients.

[2] Decrease in domiciliary beds is a result of the conversion of Waukesha, Wadsworth, and Togus and the use of domiciliary buildings at Los Angeles and Kecoughtan by the Army.

Construction is in progress or under contract to provide additional beds at existing facilities and at two new facilities as follows:

Type:	*Capacity*
General medical and surgical	950
Tuberculosis	354
Neuropsychiatric	12,221
Total	13,525

Of the additional construction which has been authorized prior to the Independent Offices Appropriation Act for 1946 which was approved by the President on May 3, 1945, four projects including two new facilities have not yet been placed under contract. These include additional beds as follows:

Type:	*Capacity*
General medical and surgical	750
Tuberculosis	100
Neuropsychiatric	1,492
Total	2,342

It is anticipated that all of these will be started within the next 90 days.

The Independent Offices Appropriation Act for 1946, previously referred to, provides for additional beds as follows, including 18 new facilities and additions at 12 existing facilities:

Type:	*Capacity*
General medical and surgical	8,000
Tuberculosis	3,400
Neuropsychiatric	2,700
Total	14,100

(Record, pt. 5, p. 2256.)

Mr. Tripp also placed in the record the Veterans' Administration estimate of the increase of neuropsychiatric patients and the estimate of the average number of beds that will be provided during the 12 months ending June 30, 1945:

It is estimated that during the 12 months ending June 30, 1945, the number of patients in our neuropsychiatric hospitals will increase by 4,550—an average increase of 379 per month. During the same period it is estimated that construction, which is now in progress, will be completed to provide a total of 8,731 additional beds for patients of this type—at an average rate of 728 beds per month. (Record, pt. 5, p. 2258.)

Mr. Raymond C. Kidd

Mr. Raymond C. Kidd, Director of the Supply Service of the Veterans' Administration, placed in the record a comprehensive statement concerning the operation of his department. This statement will be found in the record, part 5, page 2259. No testimony has been before the committee condemning in any way the Supply Department of the Veterans' Administration and in view of this fact no comments are made; your attention is directed to the substance of this statement as above cited.

Col. George E. Ijams

Col. George E. Ijams, Assistant Administrator in charge of medical and domiciliary care, construction, and supplies, was called before the committee. The Medical Department, about which there has been so much testimony in all of this record, under the table of organization of the Veterans' Administration at the time of the testimony, was directly responsible to Colonel Ijams as Assistant Administrator of the Veterans' Administration. Colonel Ijams has been with the Veterans' Administration in his present capacity for 26 years, having been first an Assistant Director of the Bureau of War Risk Insurance Assistant Director of the United States Veterans' Bureau, and Assistant Administrator of the Veterans' Administration.

Colonel Ijams, in his testimony, said in part:

* * * It is most important that the members of this committee and the public should have clearly in mind that the Medical Director of the Veterans' Administration is the supreme medical authority of our organization.

It is also important for all to realize that in all hospitals there are two distinct jobs to be done—one is the treatment of patients, the other is the hotel or housekeeping job. In most private institutions of healing private doctors are employed for the treatment of their patients in the hospitals. These hospitals also maintain a staff of resident physicians and interns who continue the treatment prescribed by the private physician when he is not present and who handle any emergencies which arise in the absence of the physician in charge of the case.

In Veterans' Administration hospitals all of our physicians of the various specialties are available for the case and treatment of all of our patients whenever their specialized services are required. Our laboratories are fully staffed and we maintain 24-hour service with graduate resident physicians always on the job, day and night.

There are many problems in the operation of a hospital other than the practice of medicine. I have mentioned the hotel or housekeeping problem. This includes construction of the buildings, their maintenance, and the purchase and distribution of supplies required by the physicians at the time and place when they are needed. This work is not related to the practice of medicine except that it provides for the doctor those things which he requires in the treatment of his patients. * * * (Record, pt. 5, pp. 2271–2272.)

In the summer of 1941 we had an ample number of general medical and surgical and tuberculosis beds to meet all of our needs. We also had a sufficient number of neuropsychiatric beds for our then known requirements. In fact, the increases in our patient load had been rather gradual during the preceding several years and

we had been able to meet all demands for beds by building approximately 3,000 beds per year. In 1940 our war industries had mushroomed in growth as we assumed contracts to supply the Allies with war materials. This brought demand for workers in these war factories at high wages. This situation in turn had quite a material effect upon our general medical and surgical hospitals. We found that men who came to us for minor surgical care when they were unemployed or were employed at low wages, were postponing medical care of this character because they were employed in war plants at high wages. As a result the load of patients in our general medical and surgical hospitals gradually diminished.

Shortly after World War I we had approximately 28,000 men in our hospitals suffering from tuberculosis, but this load had gradually diminished until we had only approximately 1,500 beds devoted to tuberculous cases in the summer of 1940. The number of our psychiatric cases had gradually increased through the years. Naturally, employment opportunities in war industries were not open to men suffering from tuberculosis and neuropsychiatric diseases. Consequently, employment opportunities in war industries produced no vacant beds from these two types of hospitals.

Because our construction work consisted principally of maintenance and operation and the construction of approximately 3,000 beds a year, the force of trained employees in our construction service had been materially reduced. (Record, pt. 5, p. 2272.)

* * * War industry jobs also brought about a decline in the number of domiciliary cases in our soldiers' homes. Even though many of these men had been domiciled in our homes over a long period of years they were able to secure employment at high wages, and I might say there that when that occurred, I realized we were scraping the bottom of the barrel, because many of them were not really employable. Very briefly, that is the picture in the summer of 1940. * * *

With this thought in mind, I discussed with the Administrator the possible effect of this increase in our armed forces on our hospital building program. This discussion resulted in a decision to await further developments before entering into a building program because at that time the number of patients in our general medical and surgical hospitals was decreasing. * * * (Record, pt. 5, p. 2273.)

Orders were also issued for the immediate removal of all patients from our 1,000-bed neuropsychiatric hospital at Los Angeles and all but the ambulant patients at our general medical and surgical hospital there. We also removed our blind and badly crippled domiciliary members from the barracks at that facility, leaving at that institution only those men who could care for themselves in case of an emergency.

The transfer of these 1,000 neuropsychiatric cases to inland hospitals presented quite a problem, but there again our previously prepared plans were found to be most effective. Doctors, nurses, attendants, and other personnel had to accompany the patients and we also had to transport beds, bedding, and other supplies with the patients as the receiving hospitals could supply only buildings in which to house them. Our field personnel responsible for these transfers to hospitals hundreds of miles away deserve the greatest possible credit for the humane and efficient manner in which these moves were made. It is difficult to transport one psychotic patient. I am glad to state that the 1,000 patients were moved to three different facilities hundreds of miles from Sawtelle without injury to one patient. (Record, pt. 5, p. 2274.)

During some months following Pearl Harbor the number of hospital cases in our general medical and surgical hospitals continued to decline but our tuberculosis and psychiatric patients increased materially. In fact, the neuropsychiatric cases represented and still represent more than 50 percent of the patients discharged from the Army and admitted directly to our hospitals for continued care. As an illustration, in July 1943, we received directly from the Army 1,693 patients. Of these, 996 were diagnosed as psychiatric cases. In November of that year there were 1,723 direct admissions from the Army of which 1,022 were psychiatric cases, and remember that a 1,000-bed psychiatric hospital is a big hospital, but we got that many in 1 month.

In March 1944 we admitted 2,172 cases directly from the Army, of which 1,409 were diagnosed as psychiatric cases. And in May 1945 we received 2,206 direct admissions, of which 1,380 were psychiatric cases. I have not quoted all the monthly figures because I want to conserve your time. * * * (Record, pt. 5, p. 2279.)

Of those, 1,380 were psychiatric cases, but these figures indicate the trend of direct hospital admissions from the Army. The figures quoted do not include

Navy admissions which were lower than the Army, nor do they include other World War II men previously discharged who came into our hospitals from civil life.

So that those figures, Mr. Chairman, do not represent all of our admissions. They are solely the direct admissions from the Army into our facilities for continued care. * * * (Record, pt. 5, p. 2280.)

Speaking of conditions in general in hospitals of the Veterans' Administration Colonel Ijams stated:

Representatives of all the major veteran organizations have not only had access to our hospitals at all times, but many of them have occupied offices in our institutions which have been given to them free of charge by their Government. Thus these men have been in a position to observe the daily operation of our institutions and have been invited by the Administrator to offer any suggestions for their improvement. * * * (Record, pt. 5, p. 2282.)

Even now we are doing our utmost to bring into our service veterans discharged from the present conflict and to place them in positions of responsibility. When the real demobilization begins, we shall no doubt be able to select discharged men of all types and of all educational backgrounds, many of whom have received specialized training while in the service. Until that day arrives, we, like all other organizations in America, shall be forced to do the best we can with the tools available to us. * * * (Record, pt. 5, p. 2288.)

While Colonel Ijams' testimony and statement were in defense of the Veterans' Administration as it was operating at that time, he brought before the committee a very clear and concise picture of the handicaps under which the Veterans' Administration has had to operate, taking into consideration priorities granted other departments of the Government, and for some reason withheld from the Veterans' Administration, which was forced to operate as any civilian hospital. The complete testimony of Colonel Ijams will be found in the record, part 5, pages 2269–2292.

Brig. Gen. Frank T. Hines

Brig. Gen. Frank T. Hines, Administrator of Veterans' Affairs, was called before the committee for his testimony pertaining to the over-all picture of the Veterans' Administration. His testimony in part was as follows:

One of the most important items that has grown out of the testimony before the committee, and the questions asked by the members of the committee, has been based upon the question of the program of hospital construction and its bearing, of course, upon the conditions which have been referred to as overcrowding. I would like to say that we are willing to admit that the hospitals, in some instances, are crowded, but we do not feel that they are overcrowded. * * * (Record, pt. 6, p. 2293.)

On the question of location of hospitals, that has an important bearing on the veterans themselves, after they are placed. Of course, you could not possibly place all of the hospitals now, or that we will have, near the large medical centers. It is possible, however, and recently one was located on the same reservation near Pittsburgh where there is a large medical school. I don't consider that the location of the diagnostic center at Hines, Ill., is out of the way, although it was proposed there that we put the hospital on the grounds of the university. * * *

* * * We have always felt that for the recovery of the patient it was important, if he was to be retained in a hospital any length of time, that he should be located where his family and his friends could pay him periodic visits. For that reason the Federal Board, and our thinking in the Veterans' Administration, has led to the conclusion that it is better to have these hospitals near the centers of veteran population. I mean the general run of hospitals. We have also felt that the neuropsychiatric hospitals should be out in the country, convenient to good transportation, but out where they are not so closely associated with large communities. They do better, and I am sure the outstanding psychiatrists who have testified here will confirm me in that view.

But in the location of the new ones now under consideration by the Federal Board we have felt wherever it was possible to divide the distance between existing hospitals of the same type that we should endeavor to do that.

Yesterday, before the Federal Board of Hospitalization, we had up a program involving the expenditure of about $180,000,000 and a large number of beds, and in the study of that program I am sure that every member of that Board was impressed with the fact that the prediction as to the number of beds since Congress passed the law to take in non-service-connected cases of World War II had been very close.

This program was based upon the request from the Veterans' Administration for 15,333 general and surgical beds, 8,137 NP beds, 2,413 TB beds, a total of 25,843 additional beds. The Federal Board's staff in its study increased the number of general and surgical beds to 17,385, the NP beds to 8,940; and reduced the TB beds to 2,150.

That study of theirs was agreed upon for the simple reason that we felt that this program, which is constantly under revision, could be reviewed and if we found a load different from what our observations are now, it could be changed.

This proposed program will increase the present hospital facilities of the Veterans' Administration from 98,577 beds to 130,432 beds; its domiciliary facilities from 15,711 to 16,600. * * *

I might explain there, Mr. Chairman, that looks like a small increase of domiciliary beds, but the fact remains that many of the facilities that will come from the Army that are well located for such purpose will create good opportunity for utilization for domiciliary cases where they cannot be used for hospital cases.

That makes a grand total of 147,052 beds. (Record, pt. 6, pp. 2294–2295.) * * *

That naturally would lead to the question why we did not anticipate this program faster. I might say that at the time—we can commence in 1940, which was prior to Pearl Harbor—we had a building program for World War I patients. World War II was not in the picture, although we were entering the training period. At that time the policy approved by the President did not require the Veterans' Administration to build more. Our beds were not all filled at that time. As a matter of fact, to tide over while the Army attempted to get ready they used some of our facilities. One of the outstanding uses was at Los Angeles, where a complete NP hospital was used as an evacuation hospital by the Army. * * *

I feel that the program has progressed rapidly and, of course this committee knows, without my telling it, that when we undertook to take in the non-service-connected cases of this war, we ran into an unusual load that neither the committee nor the Veterans' Administration could anticipate, and that has brought about a situation which is more responsible for any crowding than anything else. However, I must say that I doubt if anybody anticipated at the end of the training period that the War Department would discharge as many men in a given time. (Record, pt. 6, p. 2303.)

In speaking of the service-connected cases and non-service-connected cases, which are hospitalized by the Veterans' Administration, General Hines' testimony revealed the following figures:

I will give you that in detail; there were 15,249 TB, 46,471 NP, 104,470 general cases, 1,535 domiciliary.

To break that down further, and before doing so I might point out that March of 1945 was the largest month in numbers, when we received in our hospitals a total of 10,172. To break those down by service connected and nonservice connected, of the total of 165,790, service-connected cases were 47,806, nonservice 117,984. * * *

I have the tuberculosis group broken down. The total tuberculosis, pulmonary, was 15,249. Out of that group 10,443 were service connected; 4,816 nonservice.

I might say that that group all the way through, the great majority of them, are service-connected cases, and they, of course, need hospitalization. The Army has been prompt in turning them over to us, as well as the neuropsychiatric group. In that group we had a total of 46,071; service connected 19,894, broken into two groups—those that are definitely mental cases, psychotic cases, 16,949, and other neuropsychiatric cases, 2,945; non-service-connected cases, 26,177, of which 17,544 were psychotic, 8,629 were other neuropsychiatric disabilities.

The greatest number of the nonservice cases occurs in the general and surgical cases, where out of a total of 104,470, 86,991 were non-service-connected cases. * * * (Record, pt. 6, pp. 2303–2304.)

General Hines in speaking of the building program had the following to say:

But let me call the committee's attention to this fact; that as I am testifying here today, the building program is ahead of the personnel program. In other

words, if I could get nurses and doctors, we could open up 1,400 additional beds that are now ready to be opened up. * * *

* * * The Navy has 1,297 and civil and State institutions, 1,290. Then we had a total in our own domiciliary facilities of 9,166. Of course, before the war the Army and Navy hospitals had a large number of our cases, and it is contemplated that they will do so again.

In our total estimate of the beds required, 300,000 at the peak, assuming there is no change in the legislation, it is contemplated that where we are holding 130,000-some beds in our own institutions, that up to 200,000 of those beds will come from the Army and Navy, either from the hospitals which have been built and designed primarily to be turned over to us; that is, the permanent construction plants located at Richmond, Hines, Ill. In Georgia we have one built by the Navy, a new one planned at Austin, Tex., that will be turned over. But in addition to that, if we continue the present program, it is my judgment that we will have to build an additional 100,000 beds. (Record, pt. 6, p. 2304.)

General Hines in speaking of the difficulties encountered by the Veterans' Administration in the matter of personnel, stated:

The Veterans' Administration hospitals suffered, when the war started, in two ways. First, industry was paying high wages, and it attracted one important group from our hospitals. That was attendants. They not only were drafted to go into the service, but they left of their own accord to take positions paying more. We undertook to try to overcome that by different steps, increasing pay, and so on, but at no time could we very well reach a point to compete with industry in their pay scales and their overtime.

Our doctors, many of them, were particularly anxious to serve. They did not wish to stay in the hospitals, they wanted to serve, and you cannot blame them very much. Nevertheless, we lost to the services 450 physicians, 988 nurses, 106 technicians, 15 dentists, 17 dental mechanics, 5 dental assistants, and 1 dental hygienist. * * *

* * * Our load was increasing soon after, not immediately. But the great difficulty was there was no replacement. The replacements are still few and far between. As a matter of fact, I can't help but refer to it, and I know that the gentleman that made the remark was perfectly sincere, but I appeared before the Procurement and Assignment Committee. The Procurement and Assignment Committee was set up by the President in connection with War Manpower to avoid drawing out of any community all of the doctors, to keep a suitable number of doctors in all communities, so that men drawn into the service for the Army and Navy were channeled through this Procurement and Assignment Committee. Months went by and we could never get any doctors from the Procurement and Assignment Committee, so finally I asked for an appearance before them, based on the thought that if I couldn't get action there I would go to the President. They gave me a hearing; they listened to me. I thought I had made a very good case, when one of the members of that committee said, "Why, General, you have more doctors and nurses than you need in your hospitals." That was after we had lost this number. Not only did he make that statement at that hearing, but he came to my office and tried to convince me. I know that he was basing his thought on what were the ratios of doctors to patients and nurses in normal times, not realizing the number of doctors we had lost, although I had tried to make it clear. (Record, pt. 6, pp. 2306–2307.) * * *

Now, our doctors were not commissioned and put on detached duty until the President himself issued the order. There was a difference of opinion, an honest difference, and finally I went to President Roosevelt and told him there was only one answer, we could lose no more doctors, we could not replace them. I suggested the best method was to commission them and put them on detached duty, and he issued the order. I am not sure to this day that it was agreeable to the War Department at that time, but they did it. (Record, pt. 6, p. 2308.)

Regarding the status of the medical department within the Veterans' Administration and in defense of his position in regard to that matter, General Hines stated:

I believe that some question was raised as to whether the Medical Director of the Veterans' Administration was too far away from the Administrator, and in that way he was handicapped in his duties. The Medical Director has testified and he has answered your questions, and he has indicated that no interference has been given. We have had some discussion as to the advisability of lay managers or medical managers, but I would like to call the committee's attention to one order

setting up the Veterans' Administration. The first order followed along on July 1, 1931. The language I am now going to read to the committee has been the same from that date up to the last revision in November 1944:

The medical and hospital service shall be under a Medical Director, who shall report to the Administrator, through an Assistant Administrator, and be responsible for the proper conduct of all activities under his charge. The Medical Director shall have jurisdiction over and be solely responsible for all medical and dental service rendered claimants and beneficiaries entitled thereto under the laws and regulations governing the operation of the Veterans' Administration, and rendered under due authority on behalf of other Federal agencies and foreign governments. Such services comprehend medical and dental treatment and care for hospitalized patients, including ill or injured domiciliary beneficiaries and for out-patients rendered at field stations or in homes of entitled beneficiaries and physical and laboratory examinations for adjudication of or for medical-treatment purposes.

* * * * * * *

Naturally somebody is going to ask you why I have never appointed the Medical Director an Assistant Administrator. My answer is simply this, the activities of the medical service, with the supply service and the construction service require the closest coordination. The Assistant Administrator acts in my place wherever he is assigned. He acts there simply to coordinate the activities of the services placed under him. He acts under the delegation of authority in those matters which are delegated to him. He acts for the Administrator. Several times recommendations have been made that the Medical Director be made an Assistant Administrator. I have not seen fit, up to this time, to change the present set-up. It has functioned. I have not found any interference which if removed would enable him to function better.

But I would say in all fairness to the committee, in the bill it is contemplated, for the purpose of increasing the pay of that office, which is going to double many times in responsibilities and duties, due to the large number of men coming from World War II, that the picture in dealing with the problems of world War II, are going to require a man in that position who should, in my judgment, be paid a much higher salary than under the present classification.

But if you will go back to when we entered this war, you will find that you had very few complaints of operation of the hospitals. You heard very little about the Veterans' Administration, because the work had gone to the point where we were over the peak. Coupled with that is the fact that we consolidate regional offices with hospitals and homes. They all tie in to one thought: the peak of the work of World War I, in claims, in examinations—mind you, more than 3,000,000 men have gone through these hospitals—was over. If we could have maintained our staff, our well-trained attendants, many of these things that have been complained of would never have occurred.

There isn't any function that is as important, in looking to the future, than the training of the personnel and the keeping of your personnel in these institutions. In other words, we had abuses, yes; accidents in those hospitals. They all have them. You will never get a correct picture until you can make some comparisons of the Veterans' Administration's psychopathic hospitals with those of the States and other institutions. The attendant group must be a permanent group, well trained in how to handle these patients, or you will have more accidents. * * *

So, to my mind, one of the most important personnel problems is the establishment, as early as you can, at whatever pay scales may be necessary, of an attendant group. The turn-over in that group must not occur often. If it does, you are going to have accidents. Mind you, it is not all abuse. The attendants can only do those things that they are on the job and see. Patients, among themselves, do more damage to each other than any attendant would ever do. They require most careful attention, those who are badly disturbed, at certain periods. These abuses run all the way from a slap to some way to control the patient. Unless the attendant knows how to control a patient, he is apt to injure him and the patient would injure himself or someone else, so that I would urge the committee to do everything possible to find a way, and the way is to pay adequate salaries to carefully selected men in the various communities. Now, the pay scale has got to be flexible enough so that in a given area, where an institution is, you are able to hire people who can qualify for such work. (Record, pt. 6, pp. 2319–2321.)

In his testimony in regard to assaults by attendants upon patients in neuropsychiatric hospitals operated by the Veterans' Adminis-

tration, General Hines put into the record an office memorandum covering this subject, which goes back to 1936, and up to 1945. Because of the information in regard to these cases, this memorandum is included in this report.

Assaults by attendants upon patients submitted to Department of Justice

Received	Facility	Defendants	Charge	Action taken by Department of Justice
Oct. 6, 1936	Roanoke, Va	Zimmerman, John; Lockart, Dave.	Assault, 18 U. S. C. 455.	No prosecution.
Feb. 14, 1937	American Lake, Wash.	Deneve, Gustave	do	Do.
Aug. 21, 1937	Indianapolis, Ind	Karchner, Loren	do	Convicted.
Aug. 31, 1938	Roanoke, Va	Rickard, Carl E.; McKinley, Anderson; Skalski, J. J.	do	No prosecution.
Nov. 19, 1940	Los Angeles, Calif	Burnett, Felix W.; Brown, Robert G.	do	Convicted.
May 8, 1941	St. Cloud, Minn	Nelson, Clifford T	do	Convicted; 90 days.
Oct. 24, 1941	Roseburg, Oreg	Dirks, Howard C	do	No prosecution.
Dec. 4, 1941	Perry Point, Md	Kenney, George H	do	Do.
Dec. 31, 1941	Dayton, Ohio	Tootle, Hoyt G	do	No bill.
Jan. 1, 1942	Tuskegee, Ala	Reid, Obie D	do	Acquitted.
Apr. 14, 1942	Dayton, Ohio	Scott, Elbert; Francke, David E.	do	No prosecution.
May 5, 1942	Murfreesboro, Tenn	Mills, Orel	do	Do.
Sept. 5, 1942	Roanoke, Va	Holcomb, Thomas R	do	Acquitted.
Oct. 9, 1942	Perry Point, Md	Evans, Leon S	do	No prosecution.
Oct. 13, 1942	Fort Lyons, Colo	Lane, James A	do	Do.
Nov. 27, 1942	Lyons, N. J	Cole, John F	do	Do.
Apr. 3, 1943	Coatesville, Pa	Nelson, Clifford	do	Do.
Apr. 5, 1943	do	Ostrowski, Lawrence	do	Do.
Apr. 26, 1943	Fort Lyons, Colo	Barlow, Warren J	do	Convicted; 5 months.
May 21, 1943	Lexington, Ky	Littrell, Eddie	do	No prosecution.
July 10, 1943	Canandaigua, N. Y	Thompson, Elmer F	do	Do.
Oct. 9, 1943	Los Angeles, Calif	Peacock, Joseph V	do	Do.
Nov. 12, 1943	Bedford, Mass	Bragan, George L	do	No bill.
Nov. 15, 1943	Roanoke, Va	Moore, William G	do	Convicted; 2 years; suspended.
Dec. 10, 1943	Murfreesboro, Tenn	Davenport, Clarence	do	No prosecution.
Dec. 19, 1943	Lexington, Ky	Curtis, Arthur G	do	Do.
Feb. 19, 1944	Lyons, N. J	Kosciuk, E. P., Sheehan, Thomas.	do	No bill.
May 11, 1944	Wadsworth, Kans	Evans, John R	do	Do.
May 26, 1944	Dayton, Ohio	Riley, Harry L	do	Pending.
July 1, 1944	Tuskegee, Ala	Kurtz, John H	do	No prosecution.
Aug. 22, 1944	American Lake, Wash	Rogers, David M.; Breidenbach, L. H.	do	Do.
Aug. 29, 1944	Wadsworth, Kans	Haynes, William J	do	Do.
Nov. 4, 1944	Fort Custer, Mich	Danks, Chris	do	Pending.
Nov. 28, 1944	do	Brimingham, Ralph V	do	Do.
Jan. 16, 1945	St. Cloud, Minn	Attendants (names not known).	do	Do.
Mar. 14, 1945	Lyons, N. J	Weisshaar, Milton	Assault, manslaughter.	Do.
SENT TO UNITED STATES ATTORNEY				
Apr. 5, 1945	Downey, Ill	Gotowtis, John; Flannigan, John.	Assault, 18 U. S. C. 455.	Pending.
Do	Coatesville, Pa	Kimley, Edward	do	Do.
May 24, 1945	Perry Point, Md	Evans, Vivian P.; Lowe, Gordon K.; Seller, Charles A.; Voderey, Harry.	do	No prosecution.
May 31, 1945	Northport, N. Y	Griffin, Emet J.; Lysinger, Robert B.; Schuh, Edward J.; Stelljes, Henry; Holzworth, George; Watson, William J.; Kastik, Eric.	do	Pending.
June 5, 1945	Tuskegee, Ala	Sturgeon, Frank	do	Do.
May 5, 1945	Augusta, Ga	Attendants Carter, Crocker.		This case is now being inquired into by a central office investigator.

(Record, pt. 6, p. 2323.)

Cases not submitted to Department of Justice

Received	Facility	Attendant	
July 30, 1943	Roanoke, Va	Paugh, Clarence O	Manager recommended reprimand; he did not strike patient Ellis Dunk, C–2782652; was rough in trying to quiet him. No submission to Department of Justice.
Nov. 29, 1943	Marion, Ind	Blackman, Herman A	Rough in handling patient William G. White, C–2282800; 2 weeks' suspension; transfer recommended by committee. No submission to Department of Justice.
Mar. 17, 1943	Fort Lyon, Colo	Stuart, John R	Rough handling of patient John J. Davis, C–2905103; examined by two physicians; no evidence of injury found. Separated; no submission to Department of Justice.
Feb. 21, 1944	Chillicothe, Ohio	Sams, Elga	Board of investigation was of opinion Sams was implicated in incident injuring patient Arthur L. Fannin, C–1154480 and was "too rough in his handling of patient" Marchall Hayes, C–1806593 and recommended his discharge. Manager reports Sams "was dropped * * * as a result of unauthorized absence." No witnesses to rough handling of patients. No submission to Department of Justice.
May 2, 1944	St. Cloud, Minn	Patsch, Joseph; Matz, Joseph E.; Hoeft, Martin E.	Preliminary report referred to this office by Mr. Hiller for comment and returned to him with suggestion that while a submission to the Department of Justice appeared indicated further investigation and administrative action should first be completed. Case never submitted for this office for prosecutive action. NOTE.—Patsch resigned, others reprimanded.
Feb. 8, 1945	Lyons, N. J	Schleur, Stephen C	Board of inquiry made report; attendant not separated from rolls, no submission made.

Deaths resulting from assaults by patients or beneficiaries

Date	Facility	Assailant	Victims	Disposition of case
Aug. 20, 1936	Dayton, Ohio	Schaeffter, Sylvester.	Dr. E. M. Clark	Committed to Ohio State Hospital for Criminal Insane, Lima, Ohio.
June 29, 1933	do	Shadbolt, James	Col. Vernon Roberts, M. D.	Do.
Aug. 20, 1937	Bedford, Mass	Hunt, Bertram	John A. Sullivan, patient.	Reported to United States attorney; no action; insane.
May 24, 1939	Perry Point, Md	Jacksetic, Mike	Geo. W. Hutchins, patient.	Do.
Aug. 23, 1939	Canandaigua, N. Y.	Ward, Leroy	William J. Holman, attendant.	Reported to United States attorney; committed by United States court to St. Elizabeths.
Oct. 30, 1939	Mount Alto, District of Columbia.	Cassell, Frank	Dr. Amoine	Do.
Oct. 16, 1939	Wadsworth, Kans	Epps, Obie	Another member of home.	Convicted; sentence 30 years.
Apr. 16, 1941	St. Cloud, Minn	Beleal, Roy	Chester Mitchell, patient.	Defendant insane; no prosecution.
Aug. 3, 1936	Hines, Ill	Davis, Gilbert	James Wright, patient	Convicted; 8 years.
Nov. 23, 1936	Los Angeles, Calif	Boydson, Walter R.	Ransom P. Ham, member.	Convicted; 15 years.

(Record, pt. 6, p. 2324.)

Other assaults by patients or beneficiaries reported to Department of Justice

Received	Facility	Defendants	Victims	Disposition
Jan. 14, 1936	Tucson, Ariz	Popoff, Peter	Mrs. E. Hastings, nurse.	Convicted; 4 years.
July 14, 1936	Phoenix, Ariz	Kane, Frank	Dr. J. J. Beatty	Convicted; 10 years.
July 1, 1938	Togus, Maine	Budniak, Joseph	Guards	Convicted; 4 months.
Jan. 11, 1940	Los Angeles, Calif.	Allen, Bob	Roger Moss, member	Convicted; 15 months.
Sept. 10, 1940	Kecoughtan, Va	Calvert, Robert	Dr. E. E. Zimmerman.	Convicted; 6 months (suspended).
July 24, 1944	Los Angeles, Calif.	Holmes, Lauret	Marguerite Burns	Convicted (probation 18 months).
Mar. 27, 1945	Muskogee, Okla	Byrd, Slayton	L. L. Malsed, adjustment officer.	Pending.
May 21, 1945	Montgomery, Ala.	Kendrick, Warner.	C. J. L. Frazier, DAV representative.	Do.
1945	Hines, Ill	Triplett, Robert	Patient	Guilty; 2 years.

(Record, pt. 6, p. 2325.)

General Hines, in speaking of operating hospitals by lay managers, or the operation of the hospitals by medical men, stated as follows:

A question was raised as to the feasibility of operating a hospital with a lay manager, and the desirability of so doing. We have no objection to the assignment of a medical man as manager when he has demonstrated that he has the administrative ability to run such an institution. I do not feel that the present tendency, even in civilian institutions, large ones, is necessarily to have doctors as managers. We try, in our psychopathic hospitals, to assign, whenever you can find one, a psychiatrist that is also a capable administrative doctor, to a straight neuropsychiatric hospital.

Our combined facilities have many activities that have nothing to do with the care of the patients. In those cases the chief medical officer and his clinical director have full charge of the medical activities.

The business management of those institutions, the large ones, is a great business undertaking and requires a businessman, in many instances, to run.

No manager with good common sense would attempt to dictate to the chief medical officer or the clinical director. Very few instances of conflict have occurred. However, I know that doctors, among themselves, feel strongly that a hospital, straight hospital, should be managed by a doctor. * * * (Record, pt. 6, p. 2329.)

General Hines, in speaking of the hospital program for women, stated as follows:

We did not expand our hospitals to the full limit of the emergency beds. We thought we did. But I think we have gone far enough with the personnel. We have reached the point now where beds and wards are only opened when nurses and doctors are available. * * *

* * * I have delayed answering your request, made early this morning, on the question of beds for women. We have available, for psychotic women patients, a total of 442 beds at 7 facilities.

* * * * * * *

* * * And there are under contract 654 beds, additional beds, in 11 facilities, which would practically cover the country, but it will not provide for the final number of beds for women. We have an unusual load, about 300,000 women have been taken into the service—WAVES, WACS, SPARS, Auxiliary Corps of the Marine Corps. They are all eligible for hospitalization for service-connected or non-service-connected cases, and it might be well for the committee to give consideration to the complexity of that problem, which brings us into a little different form of hospitalization than we have had before, where we will have to have a staff of doctors that are competent to take care of women and the diseases that go with them. (Record, pt. 6, p. 2348.)

In speaking of the number of cases from World War II, which had been rated by the Veterans' Administration up to the time of his testimony, General Hines had the following to say:

* * * I would like to give the committee some information on World War II ratings, up to date.

On March 31, 1945, we had rated living veterans, and placed on the pension roll, 433,849.

For death pensions, 67,462.

Now, from March to May 31, that number had increased so that you had service-connected cases of living veterans of 499,619. Those, added to the non-service-connected, for World War II alone, 492, brought the total to 500,111.

With death service-connected cases of 84,989, and non-service-connected, 141, we have the total of 85,130.

In other words, on May 31, on the pension or compensation rolls of the Veterans' Administration were 1,095,786 living veterans.

Widows, or dependents of deceased veterans, 349,706.

Now that does not include, of course, awards made on insurance; under the national-service insurance, on the same date, May 31, we had allowed claims for 199,412. The amount of the insurance award—that is the liability for that—was $1,801,783,900. That is all World War II that I am telling you about, as to the insurance.

Some of the insurance had already been converted, for some of the men who had come out of the service, and also some death cases, of course, had been paid off. * * * (Record, pt. 6, p. 2350.)

General Hines, in speaking of the time required by the Veterans' Administration in the adjudication of claims, had the following to say:

Those claims are all adjudicated in the area boards. If the records are sent, as instructions of the War and Navy Departments contemplate, on the same day the man is discharged, the average rate at which they are adjudicating those cases in the area boards is less than 5 days. * * *

The nine area offices of the Veterans' Administration, one located in each Army command, adjudicate disability pension claims in from 1 to 5 days, on the average, following receipt of service and medical record, accompanied by application for disability pension from the War and Navy Departments, or from the regional offices of the Veterans' Administration. That is where a claim is filed by a man who has been discharged from the service, where he was discharged on a certificate of disability, it would go to the area board; where he goes and files a claim either at the discharge center or at the regional office, the regional office would handle it.

Regional offices of the Veterans' Administration, whose jurisdiction includes claims filed by persons who are discharged for reasons other than disability, or where the disabled service man or woman is discharged directly to a Veterans' Administration facility for further treatment, are adjudicating claims on the average of approximately 2½ months from the date of receipt of the pension claim.

Every effort is being made to reduce the elapsed time, although there is a certain amount of delay where supplemental service records or further medical data in the form of examinations are required.

I might say that the reexamination of these men is one of the main causes for delay.

Every effort has been made to reduce the minimum period of time which elapses between the date of receipt of a claim for death pension or compensation and the date of final action.

The large number of claims received, and the complicating factors incident to the lack of adequate personnel, have of course increased the difficulty of attaining this objective. In addition the enactment of mandatory liberalized laws has necessitated the review and adjudication of a large number of claims, particularly under Public Law 242 and Public Law 483, wherein certain rates of the Spanish War have been increased.

But in the case of the South Pacific, which is the one with the longest delay, it is due to the fact that those records do not reach us from the service department until after a considerable lapse of time. The last I saw was, I think, 39 days. * * * (Record, pt. 6, pp. 2362–2363.)

In speaking of compensation to men without dependents now treated in Veterans' Administration hospitals, General Hines testified as follows:

* * * we have had difficulty, as has been brought out, in getting World War II men to stay in those hospitals, and probably some legislation may be needed. This committee is familiar with the fact that if a veteran, a single veteran, goes into our hospital, and he is drawing more than $20 in compensation or pension, it is reduced to $20.

During the study of the economies that could be made, that was one of the provisions that was put in, but at that time we were doing what we should not

have done, by a man who is rated 10 percent going into a hospital and having his rating increased to 80 percent; therefore we were actually paying him to stay in the hospital.

Now the contention has been made, in connection with the treatment of tubercular patients, that some of those men leave the hospitals before they should because their compersation or pension is cut. That only occurs in the case of the single man, because the married man does not have his compensation or pension reduced when he goes into a hospital.

Various plans have been proposed. One is to impound the payment. Not cut it, but to give him what he needs while he is in the hospital; and others have proposed some way of rewarding him for staying in.

From the study I have been able to make, and from all I have read of the various reports, it would seem to me to be an educational program more than anything else. Some way should be found, if it can safely be done, in which these young men, who have not been home, and who go directly from an Army hospital to our hospital, for them to be given a trial visit as soon as it can safely be done. Because I am quite sure that you are not going to be able to keep the younger veteran as well as you are the man who is advanced in age and who has been in and out of the hospital and has reached the point where he feels and knows that unless he stays there the chances of him recovering are very remote.

The younger veteran does not realize that. He is impatient. He wants to get home. He wants to see his friends. So we have had difficulty in keeping those men long enough in tubercular hospitals.

Public Health will have to assist, not only in the educational program but also in the protection of public health in a given community. Most States and most cities have certain regulations where a man with active tuberculosis is not permitted to visit with people and expose other people to it. But those laws are like some of that character which are very hard to enforce and, in fact, are practically nonenforceable.

I believe that a tubercular patient should be educated, as we are trying to do. We have issued many bulletins on it. The public should assist. His family should be instructed as to the danger of infection to the family, and in the location of tubercular hospitals I believe that we shall have to avoid putting them in remote places. * * *

* * * and some of the patients stay there, and stay there a long time, but the majority will only stay a certain time; and it is not convenient for members of the family to come there, where some precuations may be taken.

When a man leaves the hospital with active tuberculosis, he becomes a real menace, not only to his family but to the community. But you have the same problem in civilian life. You have exactly that.

I feel that 90 percent of it is education of the veteran and the public and particularly of his family. * * * (Record, pt. 6, pp. 2381–2382.)

But I do know one thing, certainly; we should not go back to what we had before, and that is put the incentive on the patient staying in the hospital longer than it is necessary to get well.

I recommended—and the provision went through—to pay full compensation in the case of the man with dependents. I can see that that creates an inequality in the minds of the veterans, and I am frank to say that I believe we will have to make some adjustment. We did make a slight adjustment by boosting it up $5 a month, but that does not correct what happens in the case of a man, for instance, who comes out of an Army hospital; as long as he is there, he is generally on active duty; he may draw $50 a month. Then he goes into a veterans' hospital and draws $20, and he immediately thinks he is being penalized. (Record, pt. 6, p. 2383.)

General Hines in speaking of limiting the use of Veterans' Administration hospitals to service-connected cases, stated:

* * * I will frankly say to the committee that any attempt to limit the use of our hospitals to service-connected cases will meet with opposition, * * * there is no good reason, certainly, to take more patients in than we can properly handle, is the answer to it. The thing that bothers me, and bothers all of us, is what is going to happen to those men if we do not take them in. * * *

* * * as a matter of fact, we may be better off than many of them, particularly State and county hospitals. I heard, only recently, that a hospital up in Massachusetts practically had to close down, or limit the number they could take in because of the shortage of help, just as we are experiencing. (Record, pt. 6, p. 2384.)

In regard to the selection of professional personnel under civil service, General Hines had the following to say:

I doubt if we recognized it until we got into this war. Then we commenced to lose our doctors, and tried to replace them, and we found that those that remained available on the civil-service lists were not equal to those we had lost. (Record, pt. 6, p. 2385.)

Dr. Jerome R. Head

General Hines, in his testimony, quoted from a statement made by Dr. Jerome R. Head, who is a consultant in thoracic surgery, Veterans' Administration facility, Hines, Illinois. Dr. Head in his statement had set out the matters discussed in 1944 at a meeting of the American Association for Thoracic Surgery and recommendations were made by that Association to the Veterans' Administration. It is felt that these recommendations are of sufficient importance to include them in this report and summary and therefore the report of the American Association for Thoracic Surgery and their recommendations are given herewith:

Those of us who for many years have been medical consultants in the Veterans' Administration have developed a personal interest in the service. This interest has led naturally to a desire to contribute to its improvement. At the present time the administration is in the early stages of an enormous expansion—an expansion which will multiply manyfold the number of veterans eligible for care and consequently also the number of facilities and the number of administrators, doctors, and nurses. Realizing that for many years it will play an increasingly important place in the medical work in this country, and knowing that various changes will have to be made to meet these new responsibilities, it has seemed desirable that we make what suggestions we can for the improvement and expansion of the service. We feel that we are in a position to do this effectively, in that we are familiar with the organization as it has been functioning over the past years, and with objectivity, because we are far more interested in the work than we are dependent upon it.

It is self-evident that the purpose of the medical service of the Veterans' Administration is to supply the best possible medical care to the veterans. It is also self-evident that this is almost wholly dependent upon the ability and training of the individual physicians doing the work. The service will attract and retain the ablest physicians only if it offers them careers which are comparable in remuneration and opportunity to those which they can attain elsewhere. Heretofore, the Administration has not offered good careers to the physicians whom it employs. The pay has afforded barely a subsistence to men with families, and retirement at 70 has been on a pension of no more than $150 a month. It is common for men on being retired to have to seek other employment in order to maintain themselves for the rest of their lives.

The difference between subsistence pay and adequate pay is not great. The certainty of advancing to an adequate income and the possibility through special ability of attaining a good one, together with the security afforded by a good pension and the freedom from the worries and hardships of private practice would surely attract to the service many of the best graduates of the medical schools.

It would do this only if they felt that the nature of the work would give them an opportunity of expressing themselves and realizing their ambitions in the medical field. Most physicians are deeply interested in their work and the better ones, especially in their earlier years, are more interested in advancing the science and perfecting themselves in its practice than in acquiring money.

The administration should afford time and facilities for clinical and laboratory investigation, and should encourage it by offering advancement on the basis of contributions in these fields. It should do this, not only to attract good men to the service, but to improve the service and to fulfill its responsibilities to medicine. Advance in medicine is largely dependent upon the investigation work of practicing physicians and especially upon those who have access to copious material. For the Veterans' Bureau to take, as it will, so many physicians and so much material and make no effort to encourage scientific work, is not conducive to good practice in the service and is to neglect its responsibility to the science of medicine.

Young men entering the service should be so rotated on services that they will get a broad general training in medicine and eventually a thorough training in a specialty. They should be given time for postgraduate courses, either at the larger facilities or at outside clinics. They should be given time to attend medical meetings and conventions, and encouraged to contribute to the programs. Arrangements should be made whereby this training received in the Bureau will be accepted as credit toward the diplomas of the various accrediting boards.

It is probable that many of the younger men would enter the service solely for this training and would eventually leave and go into other work. This should be expected, and even encouraged to the extent that special arrangements should be made for training men who do not intend to remain in the service. If the permanent service is made attractive, there will be competition for the permanent positions, and the service will eventually keep the best men it has trained and, at the same time, serve a valuable function in training men for the country at large.

These men in training could be used to fill one of the great needs of the service as now conducted, namely, that of resident physicians. Today, even in the larger facilities which contain as many as 2,000 beds, only 3 physicians are on service between 4:30 p. m. and 8:30 a. m. In most instances these men are not familiar with the conditions of the acutely ill patients for whom they are responsible. It is not good practice for a neurologist or dermatologist to have to prescribe for acutely ill surgical patients whom he has never seen before.

The facilities should have adequate libraries and library services, so that all of the physicians could have immediate access to current journals and texts, and feasible access to all medical literature. These libraries should be kept open at night as well as throughout the day.

Complete diagnosis files should be kept. There should be an adequate follow-up system, and statisticians should be employed to determine the end result of treatment of the various diseases.

At the present time the cost of medical care in veterans' hospitals greatly exceeds that in private practice. This is caused by the transportation of patients to and from facilities and by unnecessarily long hospitalization. If a department were established for expediting the passage of patients through the hospitals, it is probable that the number of buildings, beds, nurses, and attendants necessary to care for eligible veterans over the coming years could be cut in half. It could be further greatly reduced if care of non-service-connected disabilities were afforded only to those who were truly indigent.

In the case of tuberculosis and probably of some other conditions, the service should be integrated with the various county and State facilities. In the case of tuberculosis it is much better that the patient be cared for close to his home, where ambulatory treatments and the necessary frequent check-ups can be taken care of by the physician who has treated him throughout his illness. If the Administration is to assume responsibility for the care of tuberculosis, it must make elaborate Nation-wide arrangements for giving pneumothorax to ambulatory patients and for following and checking those in whom the disease has been apparently arrested or arrested. Rather than do this in duplication of the city, county, and State services, it would seem preferable for the Veterans' Administration to abandon the treatment of tuberculosis and devote its energies to seeing that city, county, and State facilities are increased sufficiently to provide adequate care for all citizens.

In accordance with the ideas expressed above, the following suggestions are offered for consideration:

1. That rates of pay be increased so that after 15 years' service the minimum salary will be $8,000 a year, and that the salaries of those, who, through special administrative, clinical, or investigative ability, had attained to positions of greater responsibility, should range from $9,000 to $12,000 per year. That retirement should be at age 65 on three-quarters pay.

2. That advancement should be in part dependent upon clinical or laboratory investigations and contributions to the literature, and that time and facilities be afforded for this type of work.

3. That in the larger facilities planned rotation of services be outlined for younger men entering the Bureau so that they can receive a broad training in general medicine or surgery, and eventually in some specialty, and that this training be of such a nature that it will be accepted by the accrediting boards. That these younger men in training should live in the hospitals as residents. That their appointments should be temporary and their remuneration not more $1,800 a year. That at the end of their period of training the necessary number be chosen for permanent appointments. That men on permanent appointments who have become thoroughly competent in the larger facilities be eventually sent

out to fill vacancies or establish services in the smaller facilities from which again they might look forward to being recalled to more responsible positions in the larger units.

That the larger facilities conduct postgraduate courses to which men from the smaller facilities can be sent for short periods of advanced training.

That opportunities be given all men for clinical trips and attendance at medical meetings and conventions.

That medical library services be established or improved so that all physicians can have immediate access to current journals and texts, and feasible access to all medical literature.

That record libraries with librarians and statisticians be established so that maximum use can be made of the clinical material.

That it be part of the function of the younger physicians to work up and publish this material under the direction of the older men.

That a service be established for expediting the passage of patients through hospitals and a social service department for ascertaining the eligibility of those applying for care of non-service-connected disabilities.

It may be objected that these changes are impractical on account of the expense which they would entail. This objection is not valid for the following reasons:

1. The Veterans' Administration cannot be satisfied with less than the best medical care and these changes are essential to the best.

2. The facilities for training competent physicians throughout the country are inadequate for supplying the Administration with the necessary number of men. For this reason, the service must meet the responsibility, which is recognized by all civilian medical institutions, of training men for its own staff and for the country at large.

3. Advancement of medical science is a recognized function and responsibility of all medical organizations. It cannot justifiably be ignored by the Veterans' Administration. In addition, the quality of medical care will be better where this work is being carried on and the quality of men attracted to the service will be improved.

4. The increase of expense will be largely compensated for by the fact that much of the work which does not require experience and does not carry responsibility will be done by young and low-salaried resident physicians under the direction of the older men.

It may be objected that research and the training of younger men should not be a function of the Veterans' Administration. This objection is not valid for the following reason:

Research and the training of younger men are important and necessary functions of all good physicians and medical institutions. (Record, pt. 6, pp. 2393, 2394, 2395.)

General Hines, in his testimony, covered the entire function and operation of the Veterans' Administration and has supported his testimony with many exhibits which will be found throughout the record. The complete testimony of General Hines will be found in part 6 of this record, starting with page 2393.

Reports by subcommittee

The testimony and reports on various veterans' hospitals throughout the United States was given by members of this committee from inspections made of hospitals by the members acting as a subcommittee during the summer recess. The testimony of the members of the committee will not be reviewed in this report, as their findings and recommendations will be included in the report itself.

The testimony and the statement of Hon. Paul Cunningham, member of this committee, will be found in the record, part 1, page 343.

The testimony and report of Hon. Homer A. Ramey, member of this committee, will be found in the record, part 1, page 378.

The testimony and report of Hon. Errett P. Scrivner, member of this committee, will be found in the record, part 1, pages 426 and 443; part 2, pages 882–884; part 7, page 2629.

The testimony and report of Hon. Bernard W. Kearney, member of this committee, will be found in the record, part 1, page 476.

The testimony and report of Hon. John S. Gibson, member of this committee, will be found in the record, part 1, page 529.

The testimony and report of Hon. A. S. J. Carnahan, member of this committee, will be found in the record, part 1, page 572; part 2, page 585.

The report of Hon. Marion T. Bennett, member of this committee, will be found in the record, part 2, page 874.

The report of Hon. James C. Auchincloss, a member of this committee, will be found in the record, part 2, page 889.

The report of Hon. Charles W. Vursell, member of this committee, will be found in the record, part 7, pages 2443, 2445, 2447.

The report of Hon. A. Leonard Allen, member of this committee, will be found in the record, part 7, page 2630.

The testimony taken by Hon. James Domengeaux, member of this committee, at the Wood, Wis., facility and Milwaukee, Wis., on July 20, 21, and 24, 1945, will be found in the record, part 7, pages 2448–2628.

The report of Hon. Sherman Adams, Member of Congress, State of New Hampshire (Second District), and not a member of this committee, on the Veterans' Administration facility at White River Junction, Vt., will be found in the record, part 2, page 884.

SERVICE TO THE VETERAN

Congress has provided many services for veterans, particularly for the veteran of World War II. For him, unlike the veterans of other wars in which this country has been engaged, Congress has set up certain privileges of which he may avail himself immediately upon his separation from the service. The veteran, even before his induction into the service and while serving with troops in both training and combat areas, has been informed of these privileges and he is requesting and demanding the privileges extended to him by existing laws and regulations. Naturally, some changes will necessarily have to be made in the laws from time to time, but, as a whole, the veteran of the war in which this Nation has just been engaged will have a much better opportunity, because of the legislation now in effect, to return to his peacetime pursuits, and to resume his life in the society and the community which he left, than the veteran of the armies of any other nation.

Hospitals

The country's obligation to the veteran—and more particularly to the veteran who, as a result of his service, must be hospitalized—is a matter deserving careful and sympathetic consideration by Congress. In the course of this committee's investigation to determine the efficiency of the Veterans' Administration, and operation of the Veterans' Administration facilities, the committee considered the charge that there are many of the professional personnel, especially medical personnel, who are undesirable, incompetent, and incompatible.

While many of the medical personnel have been assigned by the War and Navy Departments to the Veterans' Administration against their own wishes and personal desires, it is difficult to believe that such personnel would render inferior service to those under their care.

Yet the record indicates that such was the case. Others of the medical personnel, chiefly nurses and attendants, have accepted appointments initially, not understanding the veteran and thereafter making little or no effort to acquaint themselves with proper methods of assisting the hospitalized veteran.

There has been much testimony in the hearings by nonmedical witnesses. These laymen, in most instances, testified to isolated but serious cases and, for the most part, neglect or abuse of patients by nonmedical personnel. Generally, these neglects or abuses were practiced upon patients (veterans) confined to hospitals for mental disabilities. In most cases, these patients were unaccountable for their actions. In some, suicidal or homicidal tendencies were part of their disabilities. The supervision and care of mental patients should be by the best professional personnel possible and those who have a sympathetic understanding of the conditions which have made it necessary to confine these veterans to this class of institution, in which many of them, of necessity, must spend the remainder of their lives. The evidence has shown that while there have been errors of medical judgment, the actual mistreatment and unprofessional care of veterans has been, for the most part, by nonprofessional personnel and in large neuropsychiatric hospitals throughout the United States.

The mentally ill

In view of the testimony of Dr. (Colonel) Verdel (record, pt. 3, pp. 1251, 1324), the reports of the Department of Mental Hygiene, State of New York (record, pt. 3, pp. 1294, 1300, 1311), and the many letters received by this committee (a very large percentage of which were written by or concerning hospitalized veterans who are now in veterans' hospitals for the treatment and care of some form of mental disorder), it is advisable to comment briefly on the general subject of keeping mental patients in veterans' hospitals.

The jurisdiction over insane persons is retained by the States, and the Federal Government has no power to restrain or confine such persons merely because they are insane; and by reason of that fact, insane veterans requiring hospitalization and restraint because they are a danger to themselves or to the public can only be hospitalized and restrained with the consent of the State of which they are residents or where they become public charges.

In order to assist insane veterans in obtaining the benefits of the various acts of Congress as to hospitalization and institutional care, the National Conference of Commissioners on Uniform State Laws have drafted and approved a uniform veterans' guardianship act. The original draft was approved at the meeting held in Seattle, Wash., July 17–23, 1928, and revised at Detroit, Mich., August 18–22, 1942.

Section 18 of this act provides that incompetent beneficiaries of the Veterans' Administration may be committed for care or treatment in Federal institutions. In substance, it provides that when a person is adjudged to be afflicted with insanity or some other mental condition, by whatever name the particular statute designates it, and to be subject to commitment to an institution, the court may commit to the Veterans' Administration facility or other agency of the United States Government, upon receipt of a certificate there-

from that such person is eligible for care by the Veterans' Administration. Upon the commitment being effected, this section confers upon the chief officer of such Federal institution the same powers with respect to retention, transfer, parole, or discharge as are possessed by superintendents of State hospitals for mental diseases in the committing State. Authority is granted by the section for transfer from State institutions to Federal agencies as well as for original commitments thereto, with a saving provision in case of so-called criminal insane, which requires special procedure. This section also expressly makes effective within the enacting State an order of commitment by the court to a Veterans' Administration facility in another State. Reciprocal legislation of this type has heretofore been enacted by various States on several subjects.

These reciprocal provisions facilitate the placing of patients in Federal institutions specially equipped to treat a particular type of mental trouble and to save the patient distress and sometimes definite harm, without a second adjudication in the State to which transferred. It also saves substantial expense to the various States, to the Federal Government, and to the patient. The right to release, by the chief officer or by judicial procedure, is retained in the committing State, notwithstanding the patient may be confined in a Federal institution in another State. This is an express statutory condition of the commitment. The substance of section 18 has heretofore been enacted in several States and has proved satisfactory.

Since the Federal Government has no power to confine or restrain an insane person against his wish or the wish of those legally responsible for him, great care must be exercised by the Veterans' Administration in placing and keeping in its facilities persons of unsound mind. Otherwise, they would be deprived of their liberty without due process of law.

The War and Navy Departments proceed in practically the same manner when it is found necessary to discharge personnel because of mental conditions rendering them unfit for further military or naval service. In both services the proper officer contacts the officials of the Veterans' Administration, who determine the eligibility of the person for admission to a veterans' facility (Army Regulations 600–500 (5) and Manual of the Medical Department of the United States Navy, sections 2160, 2173, and 2122 (d)).

In order that the Veterans' Administration may have before it all the facts necessary to determine the eligibility of any person for hospitalization or treatment, a form known as P–10 is filed, not only for those who are directly transferred from the armed forces to the Veterans' Administration but also for those who were discharged previous to their application for treatment. Those discharged from the armed services on account of mental disabilities and accepted for hospitalization in a veterans' facility will receive their discharge after transfer to such facility or such institution or hospital as may be designated by the Veterans' Administration. Thus, all veterans enter a veterans' facility upon the same basis, irrespective of the time of discharge.

The policy of the Veterans' Administration with reference to the admission of psychiatric patients under the applicable laws is clearly set forth in Regulation and Procedure 6155 as follows:

6155. [POLICY IN ADMISSION AND RETENTION OF PSYCHOTIC PATIENTS.—The general policy of the Veterans' Administration is the acceptance of eligible patients for hospital treatment upon application of the patients who are sufficiently competent, their guardians, relatives, or representatives; and the retention of patients in hospital only when desired by them, or their guardians, relatives, or representatives, or when their immediate release is contraindicated in the interest of themselves and the public. However, eligible patients who have been committed by courts of competent jurisdiction, through proceedings instituted by public officials, relatives, or representatives, can be accepted for hospitalization] (June 15, 1943).

Before an insane veteran can be lawfully accepted for hospitalization or institutional care he must make personal application, if sufficiently competent to make such a decision for himself; if not, then the application of a relative or the commitment by a court of competent jurisdiction is required.

If, after a person has been admitted by his own consent or on the application of a relative, his release is demanded, the patient must be released. But if it is determined that the release would be harmful to the person or others, before the actual release the Veterans' Administration will endeavor to have those who would be responsible for him, if released, take necessary legal steps to have the patient lawfully committed (R. and P. 6159). If that cannot be done the Veterans' Administration is authorized to take necessary steps to have the patient lawfully committed and to defray the necessary expenses of such proceeding (R. and P. 5224). This proceeding is taken only when the relative or next friend is willing to have such proceedings instituted but for some reason cannot do it, or where there is no relative or next friend.

In cases where release is demanded and the Veterans' Administration finds that it would be dangerous to the patient or to the public to release the patient and proceedings cannot be initiated to have him lawfully committed, the civil officers of his residence will be notified and arrangements made to have the patient transferred to the custody of the officials who have a lawful right to confine him (R. and P. 6159).

Employment

The ultimate solution of the broad problem of the care of the veteran, presuming he is employable, is placement in suitable and gainful occupation. If needing hospitalization he should receive the best treatment possible to restore his earning capacity. He should be awarded the compensation or pension to which he may be entitled, compensating him for the potential difference in his ability to earn, taking into consideration any disability which he has received during his service. However, it would be most unfortunate if the veteran should be allowed to believe that it is upon this compensation or pension that he must depend for his livelihood. In the case of total disability the veteran would be unable to follow any gainful occupation; but in a lesser degree of disability it is his salary or wage from a position or job that must be the keystone of his domestic economy. Compensation or pension is only supplemental to the income of the veteran

and must be considered as only a financial substitute for the reduced earning capacity due to any disability which he has received during his service with the armed forces in the defense of his country.

This would mean that the greatest assistance this Government can extend to the veteran is aiding him to finish his interrupted education or placing him in a gainful occupation or job for which he is fitted.

Investigation and study leads to the conclusion that there is immediate need for a thorough coordination of the services of many Federal agencies which have a part in the responsibility for the proper placement of veterans. The Veterans' Administration, the United States Employment Service, the National Headquarters for Selective Service, the Retraining and Reemployment Administration, and other offices are officially concerned in this matter. During the present period of partial demobilization, many complaints are reaching Congress that the veterans are experiencing difficulty in acquiring knowledge of the rights accorded them at this time. Employers cannot get dependable decisions as to their obligation to absorb recently discharged veterans and the divided authority has been used by some to avoid their responsibility. Obviously, this situation presents a serious problem to all agencies endeavoring to assist the veteran.

It is to the Veterans' Administration that the veteran of this war should look for relief in his relationship with the Federal Government, and the Administrator of Veterans' Affairs look to the consolidation of these agencies to the end that the veteran may receive the information as to his employment rights and ultimate placement directly from the Veterans' Administration.

The veteran is entitled upon his completion of duty to return to his home and to take up his rightful place in society. He is entitled to a position or employment and it is the duty of his Government, which he has served, to aid him in getting proper employment to establish his future domestic and economic stability.

Congress will insist upon an orderly and energetic program, thoroughly coordinated with the agencies charged with this all-important duty. To delay further the adoption of a properly coordinated and definite plan would be grossly unfair to the veteran with a will to work.

The reorganization of the Veterans' Administration has been studied and plans have been made for decentralizing the Administration into 13 branch offices throughout the United States, each presided over by a Deputy Administrator. Likewise, the employment and reemployment of veterans should be chargeable to these branch offices. With the problems of the veteran taken to his home community, there will be a better understanding between the veteran and the Government he has served.

Decentralization

There has been ample testimony during the investigation to show that one of the principal handicaps under which the Veterans' Administration is functioning is the overcentralization in Washington, and particularly is this true with the vast amount of work in caring for the veteran of World War II. The committee was not consulted in the preparation of the new plan of decentralization and, therefore, it

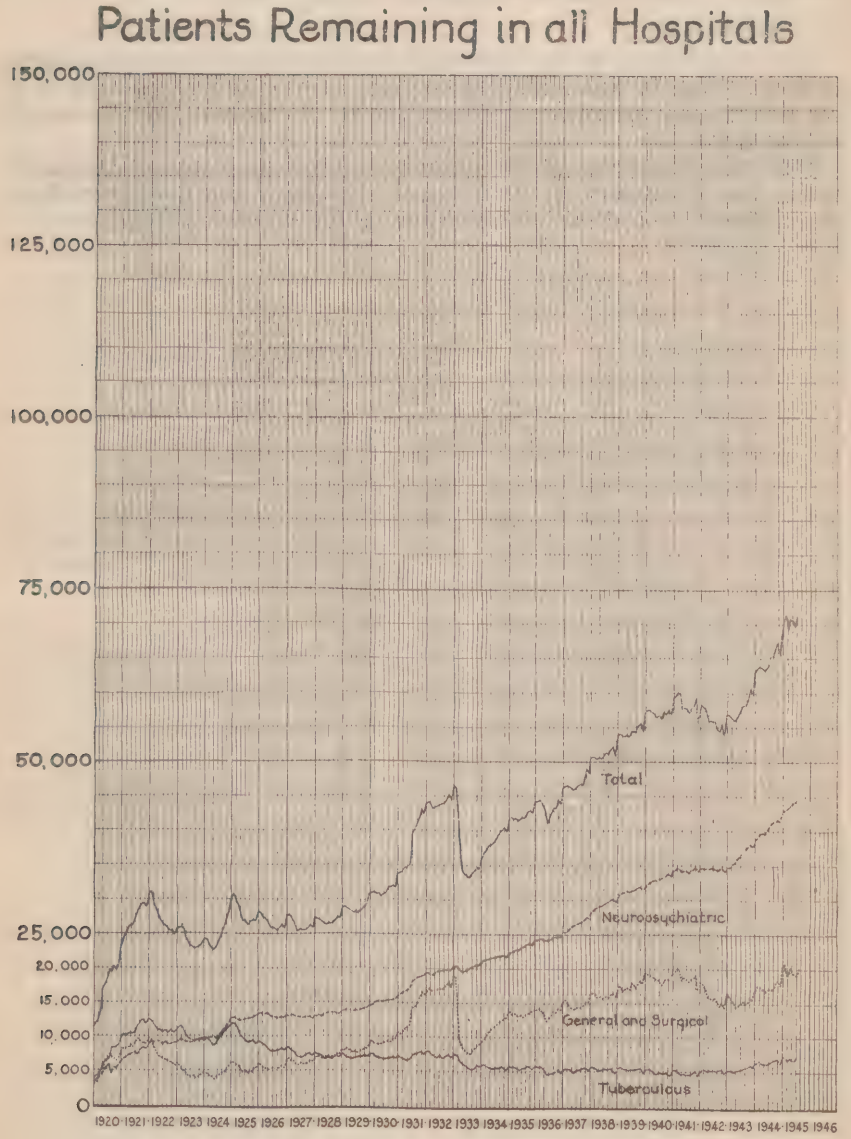
may be the territorial allotment in all of the 13 areas has been made to the best advantage. It may be that States now assigned in one area should be part of another area, to bring control closer to the home of the veteran. Should it be found the allocation of territory can be improved, changes should be made as soon as errors are discovered. Congress in general, and this committee in particular, cannot avoid the high responsibility for providing the best possible service to the former members of the armed forces, and this committee should continue to make such suggestions and recommendations as it deems appropriate in the performance of its obligations.

Care and treatment

It is felt that up to World War II, Congress had provided adequate space for hospitalization of veterans of all previous wars. This great hospital system, begun in 1919, and placed throughout the United States for the medical care and treatment of all veterans, included 91 hospitals on November 30, 1941. Since that date the number has been increased to 96. Shortly before Pearl Harbor and the entrance of the United States into World War II, an extended hospital program was considered, including hospitals which were then being constructed by the Army and the Navy. It was felt that some of these hospitals, where properly located, could be used by the Veterans' Administration in its over-all program for the care of the veteran. The Army or the Navy has, to date, released few hospitals suitable for the use of the Veterans' Administration. Following December 7, 1941, additional beds were provided in all existing Veterans' Administration hospitals and plans for construction were immediately formulated for the enlargement of many such hospitals and the building of new ones in many locations throughout the United States. From September 1919 to April 1945, a period of 25 years and 8 months, there had been 3,128,997 admissions to Veterans' Administration hospitals (record, pt. 5, p. 1845), an average over the entire period of over 10,159 patients admitted per month, or an average of over 2,349 patients admitted per week. It should be emphasized, however, that it required 25 years to build this great hospital system and that in 1919 the Veterans' Bureau had many temporary buildings, not 96 modern structures which now care for the veteran.

While there had been over 3,000,000 admissions to hospitals for all purposes, including examinations, from 1919 to 1945, there were still many men who must remain in these hospitals for proper medical care. On June 30, 1945, there were in Veterans' Administration hospitals over 5,000 men suffering from tuberculosis, almost 45,000 veterans suffering from mental diseases, and approximately 20,000 general medical and surgical cases—a total of over 70,000 hospitalized veterans. On April 30, 1945, there had been only 165,514 admissions of veterans of World War II. The great increase of admissions since May 1, 1945, has been the men and women who served in World War II. While there were only 19,922 World War II patients on April 30, 1945 (record, pt. 5, p. 1845), that figure will be increased manyfold as the men and women of World War II are discharged from the Army and Navy hospitals and require hospital treatment and after they have returned to civil life and later find that they are in need of hospital care.

The following chart shows the patients remaining in all hospitals, suffering from tuberculosis, mental diseases, and general and surgical cases, together with the total of the three services operated by the Veterans' Administration, from 1919 to June 30, 1945, and for each year of that period.



Construction

The record indicates that the Construction Service of the Veterans' Administration has anticipated, at least in part, the heavy increase and will have available many additional beds for use as the veterans present themselves for the care and treatment to which they would be entitled. (Record, pt. 1, p. 542; pt. 5, p. 2256.)

Old organization

The organization of the Veterans' Administration in existence prior to World War II was sufficient to take care of the veteran in all of the services and privileges granted him by the laws of the Nation up to that time.

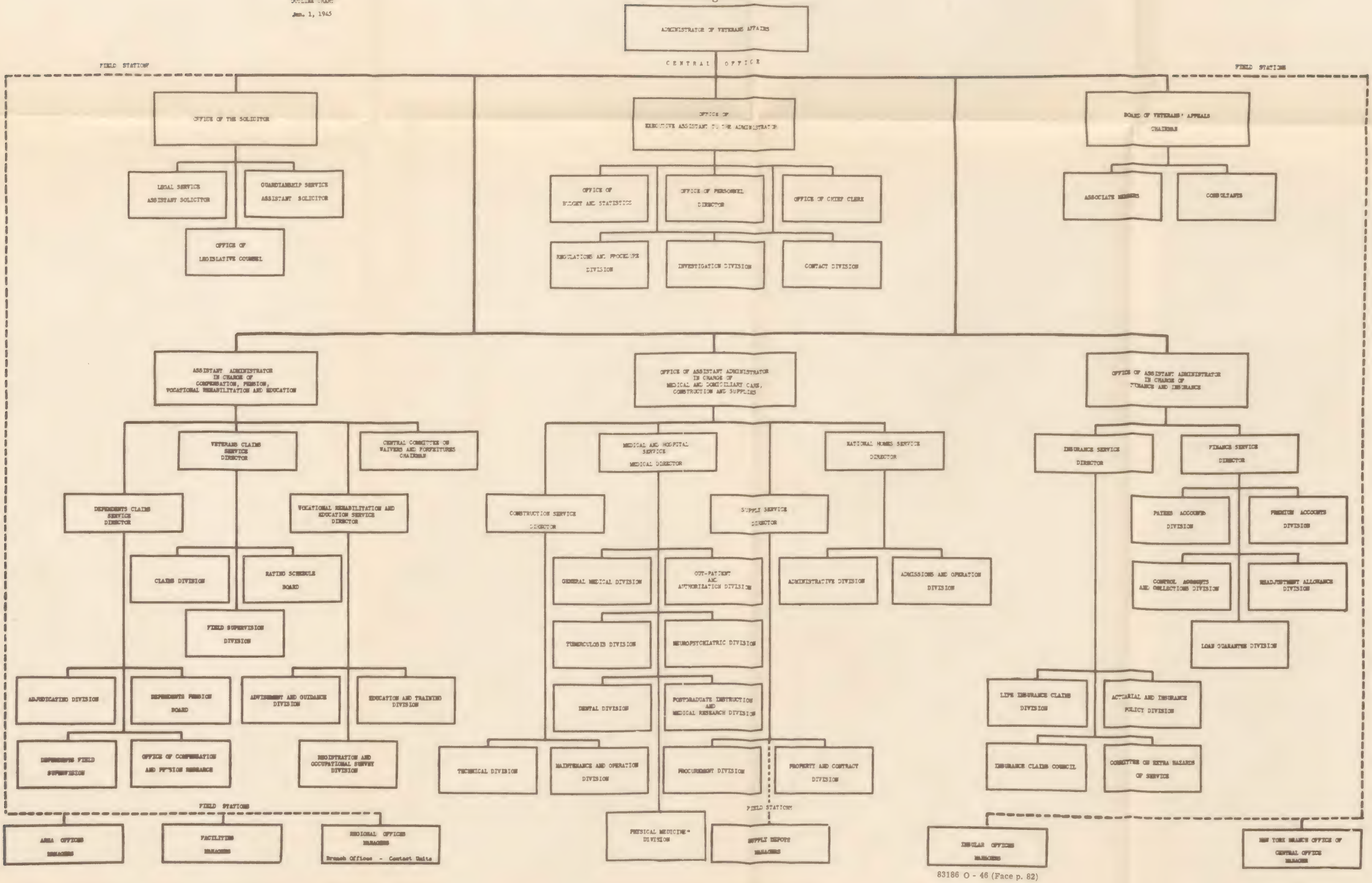
Following is a chart of the organization of the Veterans' Administration as of January 1, 1945, which will show the divisions of the organization for the care and services to the veteran at that time.

I-O

OUTLINE CHART

Jan. 1, 1945

VETERANS ADMINISTRATION
Washington, D.C.



Compensation and pension

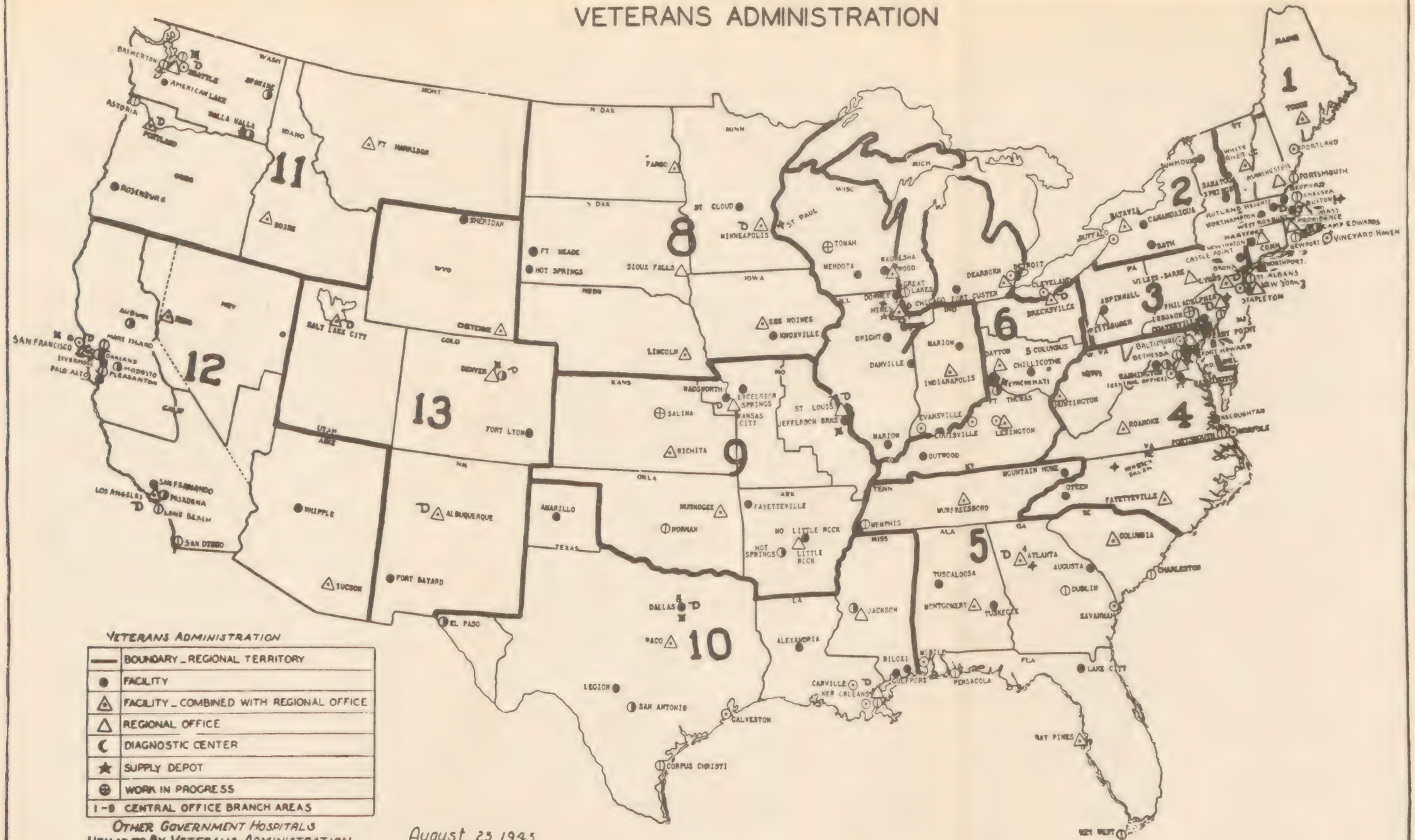
The amount of money to be expended by the Veterans' Administration in carrying out the public and special acts of Congress will be enormous, and that amount will increase materially in the next few years until it has reached a point probably not realized by many when referring to the Veterans' Administration as an agency of this Government for the care of the "disabled" of this and former wars. At the close of the fiscal year June 30, 1945, exclusive of insurance, subsistence allowance, and readjustment allowances, the Veterans' Administration carried on its rolls, by public and special acts, 1,144,088 living veterans, which represented an annual value in money of $625,069,044. On the same date there were 369,498 dependents of deceased veterans to whom the Veterans' Administration were paying annually $204,275,616. At the close of the fiscal year of 1945 very few veterans of World War II, comparatively, had been placed on the rolls of the Veterans' Administration, for the reason that thousands of veterans of World War II had not filed applications with the Veterans' Administration or had not been released from service.

A statement showing, by wars and the Regular Establishment and by public and special acts, the number of living veterans who were receiving monetary benefits, the number of deceased veterans whose dependents were receiving monetary benefits, and the aggregate annual value of these benefits on June 30, 1945, exclusive of insurance, subsistence allowance, and readjustment allowances, is included in this report as follows:

Wars and Regular Establishment	Total		Public acts		Special acts	
	Number	Annual value	Number	Annual value	Number	Annual value
Grand total	1,513,586	$829,344,660	1,510,336	$828,302,468	3,250	$1,042,192
Living veterans	1,144,088	625,069,044	1,143,398	624,923,784	690	145,260
Deceased veterans	369,498	204,275,616	366,938	203,378,684	2,560	896,932
War of 1812: Deceased veterans	1	240			1	240
Mexican War: Deceased veterans	55	31,704	51	30,600	4	1,104
Indian wars	3,788	2,159,760	3,727	2,145,492	61	14,268
Living veterans	1,115	940,356	1,097	936,972	18	3,384
Deceased veterans	2,673	1,219,404	2,630	1,208,520	43	10,884
Civil War	24,750	11,349,008	22,596	10,599,680	2,154	749,328
Living veterans	229	272,100	226	270,300	3	1,800
Deceased veterans	24,521	11,076,908	22,370	10,329,380	2,151	747,528
Spanish-American War	200,059	141,468,900	199,893	141,420,264	166	48,636
Living veterans	128,104	110,323,908	128,043	110,307,924	61	15,984
Service-connected and special act cases	901	1,037,652	840	1,021,668	61	15,984
Non-service-connected	127,203	109,286,256	127,203	109,286,256		
Deceased veterans	71,955	31,144,992	71,850	31,112,340	105	32,652
Service-connected and special act cases	1,315	754,452	1,210	721,800	105	32,652
Non-service-connected	70,640	30,390,540	70,640	30,390,540		
World War I	587,589	320,483,928	587,587	320,482,368	2	1,560
Living veterans	425,589	231,974,772	425,587	231,973,212	2	1,560
Service-connected and special act cases	332,628	177,999,144	332,626	177,997,584	2	1,560
Non-service-connected	90,477	49,910,004	90,477	49,910,004		
Emergency officers' retirement	2,475	4,050,804	2,475	4,050,804		
Provisional, probationary, or temporary officers' retirement	9	14,820	9	14,820		
Deceased veterans	162,000	88,509,156	162,000	88,509,156		
Service-connected	84,416	50,422,728	84,416	50,422,728		
Non-service-connected	77,584	38,086,428	77,584	38,086,428		
World War II	640,753	$329,129,700	640,753	$329,129,700		
Living veterans	546,126	263,082,036	546,126	263,082,036		
Service-connected	536,541	245,109,216	536,541	245,109,216		
Non-service-connected	543	205,704	543	205,704		
Reserve officers' retirement	9,042	17,767,116	9,042	17,767,116		
Deceased veterans	94,627	66,047,664	94,627	66,047,664		
Service-connected	94,463	65,965,860	94,463	65,965,860		
Non-service-connected	164	81,804	164	81,804		
Regular Establishment	56,591	24,721,420	55,729	24,494,364	862	$227,056
Living veterans	42,925	18,475,872	42,319	18,353,340	606	122,532
Deceased veterans	13,666	6,245,548	13,410	6,141,024	256	104,524

The figures in the above chart are most enlightening. This would indicate that on June 30, 1945, there were only 53,164 more World War II veterans receiving benefits from the Veterans' Administration than World War I veterans. Bearing in mind that there were almost four times as many men and women inducted into service for World War II than those inducted for World War I, with primarily the same

VETERANS ADMINISTRATION



VETERANS ADMINISTRATION

—	BOUNDARY - REGIONAL TERRITORY
●	FACILITY
◬	FACILITY - COMBINED WITH REGIONAL OFFICE
△	REGIONAL OFFICE
☾	DIAGNOSTIC CENTER
★	SUPPLY DEPOT
⊕	WORK IN PROGRESS
1-9	CENTRAL OFFICE BRANCH AREAS

OTHER GOVERNMENT HOSPITALS UTILIZED BY VETERANS ADMINISTRATION

◎	FEDERAL SECURITY AGENCY
◑	ARMY ✖ CIVIL SERVICE REG HQ
◍	NAVY
D	TREAS. DISB'MT OFFICE

August 25 1943

83186 O - 46 (Face p. 84) No. 1

VETERANS ADMINISTRATION

THE SOLE PURPOSE

TO RENDER SERVICE TO SOME 20,000,000 VETERANS THEIR DEPENDENTS OR BENEFICIARIES

A
Administrator of Veterans' Affairs

D
Office of the Director of Coordination and Planning
- Assistant Director
  - 1 Research Service
  - 2 Administrative Management Service
  - 3 Employees Suggestion Service
  - 4 Inspection and Investigation Service
  - 5 Budget and Planning Service

E
Executive Assistant Administrator

R
Office of the Director of Public Relations
- Assistant Director
  - 1 News Service
  - 2 Radio Service
  - 3 Development Service
  - 4 Visual Aids Service
  - 5 Field Service

S
Surgeon General
- Special Advisory Group
- Assistant Surgeon General

CENTRAL OFFICE

OFFICE / SERVICE

1 Chairman Board of Veterans' Appeals
- Vice-Chairman
- 1 Associate Members'
- 2 Chief of Consultants
- 3 Administrative Division
- 4 Assistant to Chairman

2 Solicitor
- 1 Legislative Service
- 2 Legal Service
- 3 Guardianship Service

3 Assistant Administrator for Contact and Services
- Executive Assistant
- 1 Contact Service
- 2 Administrative Service

4 Assistant Administrator for Finance
- Executive Assistant
- 1 Payee's Accounts Service
- 2 Readjustment Allowance Service
- 3 Control Accounts Service
- 4 Loan Guarantee Service

5 Assistant Administrator for Personnel
- Executive Assistant
- 1 Classification Service
- 2 Personnel Management Service
- 3 Personnel Operations Service
- 4 Field Supervision Service

7 Assistant Administrator for Vocational Rehabilitation and Education
- Executive Assistant
- 1 Registration and Research Service
- 2 Advisement and Guidance Service
- 3 Training Facilities Service
- 4 Education and Training Service

8 Assistant Administrator for Claims
- Executive Assistant
- 1 Veterans Claims Service
- 2 Dependents and Beneficiaries Claims Service
- 3 Central Committee on Waivers and Forfeitures

9 Assistant Administrator for Insurance
- Executive Assistant
- 1 Underwriting Service
- 2 Disability Insurance Claims Service
- 3 Actuarial Service
- 4 Insurance Accounts Service

10 Assistant Administrator for Medical Administration
- Executive Assistant
- 1 National Homes Service
- 2 Professional Services
- 3 Plans and Operating Service
- 4 Out-Patient Service
- 5 Hospitalization Service
- Research & Graduate Training: Supervision, Dental, Nursing, Tuberculosis, Neuropsychiatric, Social Service, General Medicine, General Surgery

11 Assistant Administrator for Construction and Supplies
- Executive Assistant
- 1 Construction Service
- 2 Supply Service

6 Office of the Director of Special Services
- Assistant Director
  - 1 Canteen Service
  - 2 Recreation and Entertainment Service
  - 3 Athletic Service
  - 4 Fiscal and Administrative Service
  - 5 Chaplaincy Service
  - 6 Library Service
  - 7 Red Cross and Volunteer Service

13 Branch Offices
Having Supervision of Policy and Performance. Administrative and Technical Control
5. Atlanta, Ga.
1. Boston, Mass.
7. Chicago, Ill.
6. Cincinnati, Ohio
10. Dallas, Texas
13. Denver, Colo.
8. Minneapolis, Minn.
2. New York, N.Y.
3. Philadelphia, Pa.
9. St. Louis, Mo.
12. San Francisco, Calif.
11. Seattle, Washington
4. Richmond, Va.

BRANCH OFFICES

D
Deputy Administrator

AD
Assistant Deputy Administrator

P
Director of Coordination and Planning Service

R
Director of Public Relations Service

DS
Deputy Surgeon General
- Executive Officer

To be Decentralized to this level when need requires

SERVICE

1 Board of Appeals
- Assistant

2 Assistant Solicitor
- Assistant

3 Director of Contact and Services
- Assistant Director
  - Contact Division
  - Administrative Division

4 Director of Finance Service
- Assistant Director
  - Payee's Accts Div.
  - 2 Readjust. Allow. Div.
  - 4 Loan Guarantee Div.

5 Director of Personnel Service
- Assistant Director
  - Classification Div.
  - 2 Management Div.
  - 3 Operations Div.

7 Director of Vocational Rehabilitation and Education Service
- Assistant Director
  - Registration and Research Div.
  - Advisement and Guidance Div.
  - 3 Training Facilities Div.
  - 4 Education and Trng. Div.

8 Director of Claims Service
- Assistant Director
  - Veterans Claims Division
  - Dependent and Benef. Claims Div.

9 Director of Insurance Service
- Assistant Director
  - Underwriting Div.
  - Disab. Ins. Claims Div.
  - 4 Insurance Accounts Div.

10 Director of Medical Administration Service
- Assistant Director
  - National Homes Div.
  - 2 Professional Divs.
  - 3 Plans and Operating Div.
  - 4 Out-Patient Div.
  - 5 Hospitalization Div.
  - Research and Graduate Training: Supervision, Nursing, Tuberculosis, Neuropsychiatric, Social Service, General Medicine, General Surgery

11 Director of Construction and Supplies Service
- Assistant Director
  - Construction Div.
  - 2 Supply Div.

6 Director of Special Services
- Assistant Director
  - 1 Canteen Div.
  - 2 Recreation & Ent. Div.
  - 3 Athletic Div.
  - 4 Fiscal and Adm. Div.
  - 5 Chaplaincy Div.
  - 6 Library Div.
  - 7 Red Cross & Vol. Div.

HOSPITALS

DIVISION

M
Manager
- Public Relations
- Assistant Manager
  - Chief Medical Officer Professional Division
  - Executive Officer Administrative Division
  - Chief of Special Services Division

Insular Offices

REGIONAL OFFICES

M
Regional Manager
- Coordination and Planning
- Assistant Manager
- Public Relations
- 2 Chief Attorney
- 3 Chief Contact and Services
- 4 Finance Officer
- 5 Personnel Officer
- 7 Chief Voc Rehab and Education
- 8 Adjudication Officer
- 9 Insurance Officer
- 10 Chief Medical Officer
- 11 Supply Officer

SUB-REGIONAL OFFICES

Manager

SECTION

2 | 3 | 4 | 7 | 9 | 10 | 11

UNIT
- Contact Unit
- Itinerant Service

Revised to 10-27-45.

83186 O - 46 (Face p. 84) No. 2

benefits, one can readily understand the large number of veterans and dependents of veterans and the great amount of money which the Veterans' Administration will be called upon to expend in the years just ahead.

At the close of the fiscal year (June 30, 1945), there were 332,626 living veterans of World War I receiving monetary benefits of an annual value for service-connected disabilities amounting to $177,997,584. On the same date the Veterans' Administration had placed upon the rolls from World War II, with service-connected disabilities, 536,541 living veterans who would receive annual benefits in the amount of $245,109,216. On the same date there were 90,477 veterans of World War I with non-service-connected disabilities, with an annual value of $49,910,004, and only 543 veterans of World War II with a non-service-connected disability, with an annual money value of $205,704.

On June 30, 1945, there were 546,126 living veterans of World War II receiving service-connected, non-service-connected pension, and Reserve officers' retirement. This represents an annual value in money of $263,082,036. Recalling that on June 30, 1945, the Veterans' Administration was carrying approximately 20 percent of the anticipated work load that would come to the Administration in caring for the veterans of World War II, and projecting the above figures as to living veterans (both service-connected and non-service-connected), it is clearly indicated that in the years immediately ahead there will be slightly more than 2,500,000 veterans drawing service-connected, non-service-connected pension, and Reserve officers' retirement through the Veterans' Administration. This would represent an annual value in money of approximately $1,300,000,000, to be paid through the Veterans' Administration for living veterans of World War II.

The above figures are cited to show something of the large expenditures anticipated within the next generation for the care of veterans of World War II. These figures, of course, do not include the payment which would be made to the dependents of deceased veterans of World War II and, of course, are exclusive of both classes of veterans for insurance, subsistence allowance, and readjustment allowances.

New organization

In anticipation of giving the veteran the proper service and care to which he is entitled, the reorganization of the Veterans' Administration is now in the process of a vast expansion. On September 14, 1945, this reorganization and expansion was announced by the Administrator of Veterans' Affairs, Gen. Omar N. Bradley, and on the same date, for administrative purposes, the United States was divided into 13 branch-office areas, with the central office of the Veterans' Administration being retained in Washington. A map showing the boundary lines of these areas is included in this report.

Some idea of the vast expansion and the organization that will handle the service and care of the veteran may be seen from the organizational chart, approved September 14, 1945, revised to October 27, 1945.

The Administrator

The Administrator of Veterans' Affairs, Gen. Omar N. Bradley, speaking before the Veterans of Foreign Wars of the United States at their forty-sixth annual encampment at Chicago, Ill., on October 2, 1945, stated, in part:

On September 14 I announced a plan of decentralization that will create a system of 13 branch-office areas.

Under this system, hospitals and regional offices will report to the branch office. Sufficient authority will be delegated the branch manager to permit decisions within the framework of our policies. He will be held responsible to Washington for the operations of his area. He will directly supervise and administer installations within his jurisdiction, helping to break the bottlenecks that develop from constant reference to Washington.

No one is more deserving of benefits provided veterans by Congress than the man disabled in wartime service. To help him, we shall encourage modern progressive medicine in the treatment of all patients.

Up to now, we have constructed hospitals of various types over the country to bring our service nearest the veteran. Because of the critical shortage in professional personnel, we think a change may be necessary. We believe that smaller hospitals can be located to perform emergency service in centers of veteran population. Larger hospitals also providing specialized treatment can then be constructed where medical centers and consultant service are readily available. In this way we can provide the high standard of treatment to which veterans are entitled and insure the specialization necessary for modern medicine.

Many will require medical care or rehabilitation. Others will want education. Still others will buy homes, purchase farms, or start in business. Many will file disability claims. All are clients of the Veterans' Administration.

I say clients, because we shall regard them as such. Veterans have earned the benefits we are authorized to provide them. I shall not knowingly keep or hire any employee unmindful of that fact. Unless we can think of these men as the earnest young men with whom we fought, as anxious to establish themselves as they were to defeat the enemy, we shall fail miserably in what we have set out to do.

Although the Veterans' Administration is not charged with the task of finding veterans jobs, we are directly concerned with the program. If a solution is found to the need for jobs we can prove to the world that this nation, which met the test of war, can turn its talents as effectively to the reestablishment of peace.

If you anticipate miracles overnight, you will be disappointed. In the two-and-one-half-billion-dollar business of human relationships in which we are engaged, changes take time.

General Bradley, speaking before the Disabled American Veterans at their national convention in Chicago, Ill., on October 20, 1945, stated in part:

With the war ended, we have its aftermath in the disabled and weakened bodies of men who must be helped to recover. This is the most morally significant post-war problem confronting us today. It involves an obligation to our wounded inherent in the debt of democracy to the men who suffered most to save it.

We have a greater obligation than that of simply attending to routine needs and comforts of our patients. As far as possible, they must be helped, assisted, and restored by curative medicine and progressive rehabilitation as useful members of their communities.

Cut-backs in wartime medical training have confronted us with a Nation-wide shortage of doctors, among civilians as well as in Government service.

Fortunately, however, our position is not impossible.

Some doctors have told us they will come with us if we can offer them more attractive salaries, chances for professional advancement, and the opportunity to practice modern medicine.

We mean to provide all three.

Our medical service exists to benefit the veteran. It will do so with all the talent and ingenuity at our disposal.

Doctors who enter this medical corps will not be taken in through the civil-service system. Instead they will be selected by the Administrator on the basis of their professional qualifications.

In addition we shall make full use of doctors as consultants or on a part-time basis.

At present we have some excellent doctors and some good ones. Much of their work has been outstanding. At the same time, we also have our poor ones. We hope to drop these as soon as they can be replaced.

Although consultants and outside physicians have always been available to the Veterans' Administration to supplement the work of their own doctors, we feel that full use has not been made of their talents. It has been the custom to depend upon our own full-time staffs, asking assistance only in emergencies and special cases. We want to encourage the medical profession to contribute their great talents.

Good medicine can only be developed in a free and open exchange of information with the medical profession, utilizing the skills and know-how that can benefit our patients.

Overtures have already been made to the medical profession. Their response has exceeded our expectations. These consultants—who will actually comprise a visiting staff to our hospitals—are enthusiastic in their desire to serve.

If we mean to employ the services other physicians have offered, more hospitals must be constructed near large urban medical and teaching centers.

Where we have hospitals near great teaching centers, we can encourage outstanding men with their principal assistants to join us as consultants. Full-time resident physicians can then be employed and trained under their supervision.

Inaccessible rural hospitals can be used primarily for institutional care. To these hospitals can be sent the chronic cases that will not respond to active medicine but are still not in condition for domiciliary homes. Such cases require more nursing care than actual medical service.

For the first time, we are faced with the necessity of caring for women veterans. Eventually more than 300,000 of them will become eligible for medical treatment. Obviously, it is impracticable to establish a network of separate women's hospitals. Better treatment can be provided them in women's wards and wings in hospitals planned for early construction. It will be necessary to add to our staff specialists in diseases and disorders peculiar to their sex.

Official forms and paper work have always handicapped our doctors and nurses. To avoid this waste of valuable medical talent, we are establishing a medical administrative service. This aims to relieve doctors of paper details, leaving them freer to practice medicine.

Post exchanges will be created to replace concessions in hospitals and domiciliary homes. We believe this service can provide more for our patients at considerably less cost. Small profits can be reinvested in additional recreation.

To stint on hospital service, to weigh the care we owe veterans in a shadow of financial timidity, would break faith with the very men to whom we owe the most.

Pensions are an integral part of the Government's responsibility to give disabled veterans an even footing with those who returned uninjured.

Our pensions have not always satisfied this need.

We believe pensions must permit adequate compensation that veterans shall not be handicapped in achieving a reasonable standard of living.

The man who has fought—and is wounded—in securing for others the right to attain a living cannot—with justification—be denied that living himself.

General Bradley, in speaking before the American Legion at their national convention in Chicago, Ill., on November 20, 1945, again outlined many of the policies which he hopes to put into effect, and said, in part:

Where we once pinned our faith on these men in battle, they now pin theirs on us for a chance to make good in this world to which they have returned.

Until these millions of returning veterans find employment, until they rebuild their lives and resume their responsibilities, the war is not ended and we cannot escape our continuing duty to them. We have them with us now as part of the human aftermath of war.

Those of you who returned as veterans from the last World War know how quickly the banners of welcome fade. For in 1918 and 1919 there was no GI bill of rights. In the sudden shift from war to peace, veterans found a no man's land. There was no thoughtful, well-ordered effort to make civilians of our soldiers.

For the first time, the United States has accepted this promise. In the GI bill of rights we find a human document which—despite its imperfections—

remains the nearest we have come to an intelligent solution to our human needs in the wake of war.

Almost as important as jobs is the attitude of the American people. The veteran will naturally respond to gratitude or grow resentful if ignored. For he is refitting himself to a life abandoned several years ago and in many instances strangely foreign to the one he led in service.

Despite the valuable aid we shall get from part-time physicians and visiting staffs, it is nevertheless essential that we staff our hospitals with a greater number of competent full-time physicians. This becomes particularly important as Army officers assigned to us for duty during the war are relieved for discharge from the service.

Under present civil-service laws we cannot hope to fill our needs. Additional inducements must be offered doctors if they are to make careers in the Veterans' Administration.

Certainly any young doctor, primarily interested in making money, is not coming with us regardless of what we can offer. Even if we wanted him, the Government cannot compete with the top rewards of private practice. However, we feel that doctors must be offered incomes substantial to make the work agreeable—and opportunity enough to make it attractive. We feel that many doctors will want, first, the chance for honest service; and, second, sufficient pay to afford reasonable security together with the freedom to practice good modern medicine.

As an agency constructed to care for the needs of 4,000,000 veterans from the First World War, the Veterans' Administration could hardly take on 15,000,000 more without substantial overhauling.

* * * we soon learned it was obviously impossible to handle our business from the central office in Washington.

With the creation of 13 branch offices, we shall achieve effective supervision that could not otherwise be obtained. With each manager responsible for the 10 or 15 hospitals and regional offices within his district, this direct supervision should bring greater operating efficiency.

I know of nothing more urgently needed today than the development of soundly directed, locally supported community centers that will give veterans a one-stop answer to the peculiar problems confronting them on their return.

Throughout this entire program of Veterans' Administration—in our hospitals and in the community—we shall insist that our service be measured by the only standard we employ. That is, it benefit the veteran for whom it is intended.

General Bradley has expressed himself very forcibly before the veterans' organizations of this Nation. His remarks have been followed closely. General Bradley, in outlining his administrative program and his ideas to the veterans' organizations, has gone far in bringing about the cooperation needed for the efficient operation of the vast organization which must serve the veteran of this and other wars. He has also well interpreted the sentiments of this committee and the mandates it has provided in the most comprehensive and progressive legislation ever enacted for veterans in this or any other nation.

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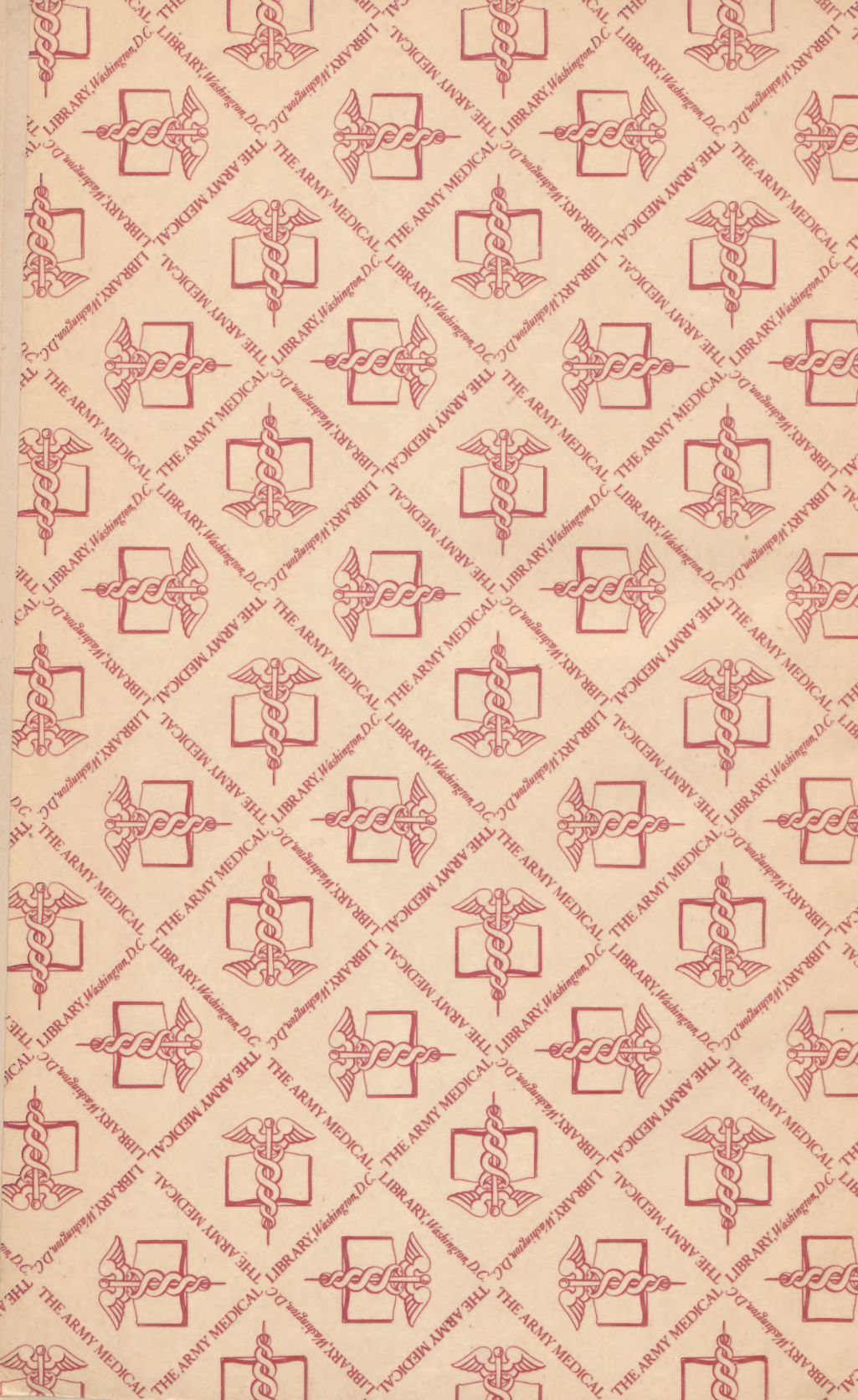
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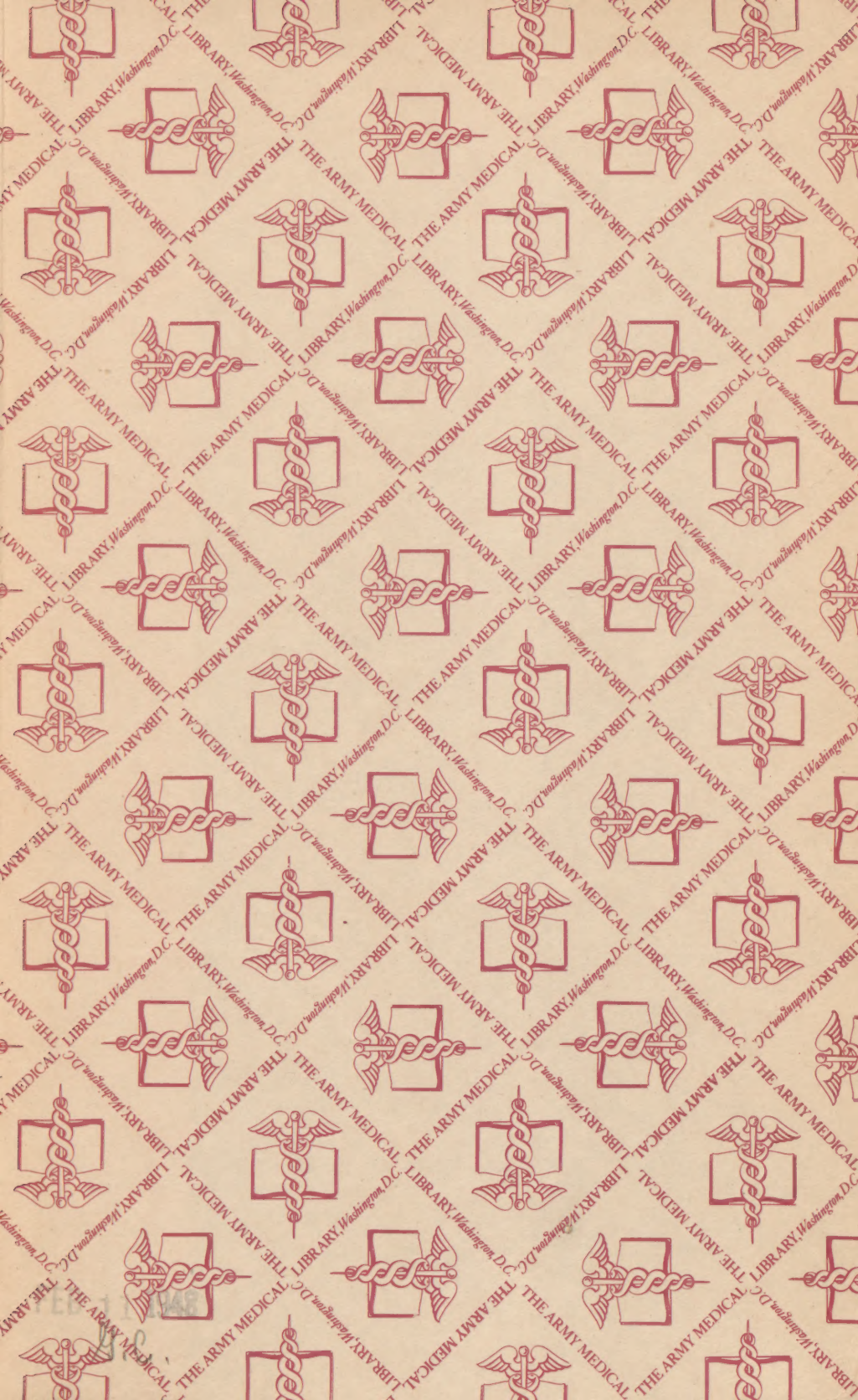
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